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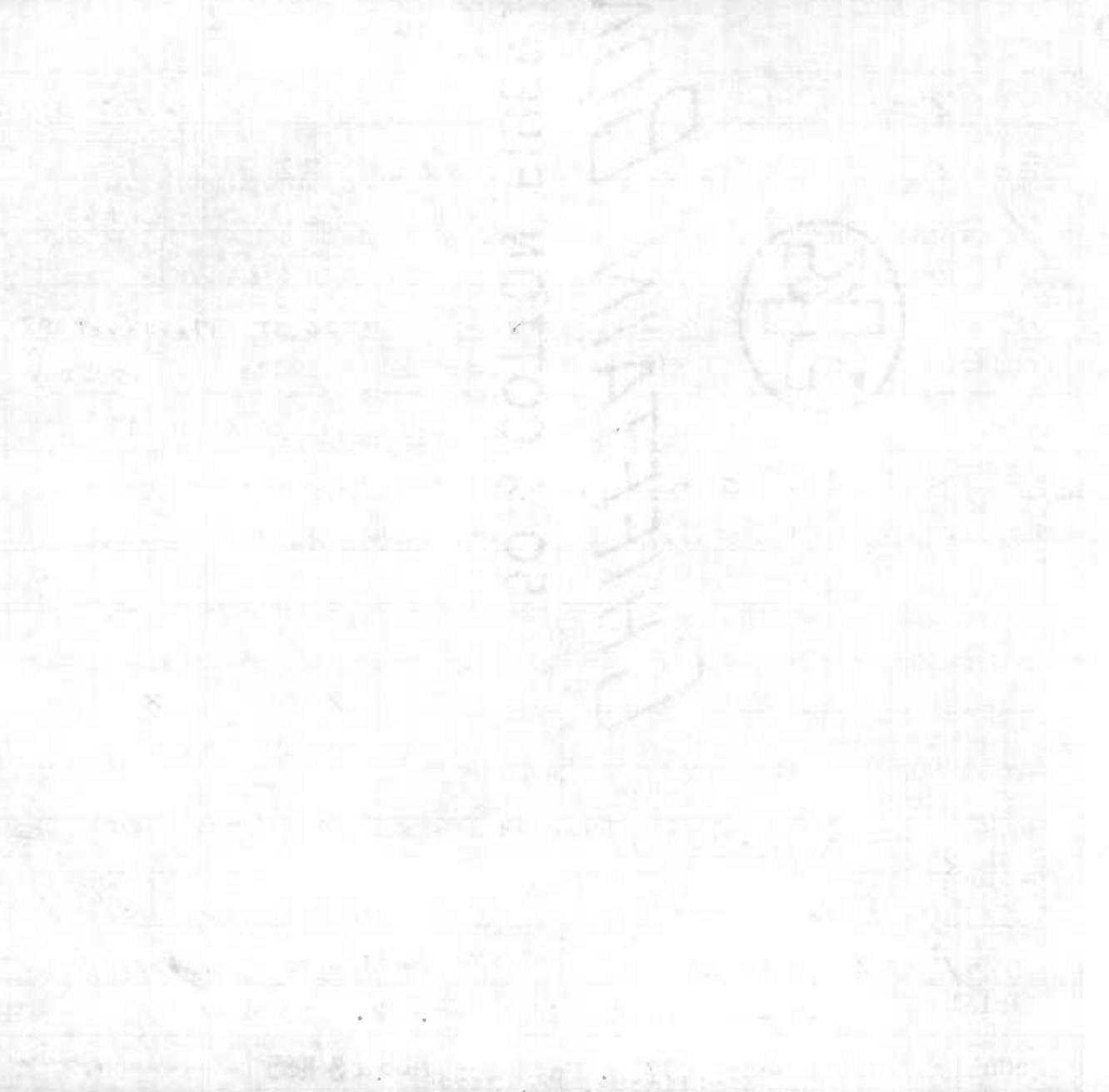
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Ethel</i>					<i>Watts</i>	8	12	85	2:45 PM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		10 5 07		77 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
NC		U.S.A.				Baltimore City.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore						Disable		21225 3726 ST. Margaret ST			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		ADDRESS	
MD				Baltimore				3726 ST.		Same as #13	
14. FATHER'S NAME		MIDDLE	King		15. MOTHER'S MAIDEN NAME		Martha Belle		Godfrey		
Benjamin											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		243-01-8165		Lee Davis Watts		Intrahepatic obstruction					
18c. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (18a), stating the underlying cause lost		(b) Carcinoma of the bile duct.									
18c. DUE TO, OR AS A CONSEQUENCE OF		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 24, 1985, to August 12, 1985, that (I) (we) lost saw the deceased alive on August 12, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Rafael E. Espinosa</i>		22c. DEGREE M.D.		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22e. DATE SIGNED 8/12/85					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rafael E. Espinosa</i>		22g. ADDRESS South Baltimore General Hospital									
23a. BURIAL, CREMATION, REMOVAL IS BURIAL		23b. DATE 8-15-85		23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk. Baltimore		23d. LOCATED IN COUNTY		Maryland			
24. FUNERAL DIRECTOR McCully Funeral Home		25a. DATE REC'D. BY REGISTRAR AUG. 13 1985		25b. REGISTRAR'S SIGNATURE <i>John J. McCully</i>							
B.P.											
DHMH - 16 60M 7/B4 (VRA 15, 4)											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper, page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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22149

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)				FIRST George	MIDDLE Wm	LAST Webb Sr.	2a. DATE OF DEATH MONTH March	DAY 26	YEAR 1913	2b. HOUR 8:40 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH March		DAY 26	YEAR 1913	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7b. HOUR IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital, Balto. Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machine Operator, Glass Co.				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		14. FATHER'S NAME FIRST James		MIDDLE -----	LAST Webb	15. MOTHER'S MAIDEN NAME FIRST Nora	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-05-6681		17. INFORMANT Mrs. Helen M. Webb, Same as above				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for item 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Squamous cell carcinoma of lung (left)													
19a. DATE OF OPERATION 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell carcinoma lung				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) NO		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 19 85		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) n/a									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -----		21f. LOCATION STREET -----		CITY OR TOWN -----		COUNTY -----	STATE -----				
22a. I certify that (if this hospital) attended the deceased from Sept. 1, 1982 to Aug. 31, 1985 , thus (if well) last saw the deceased live on 8/13 1985 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If well and did not view the body after death)													
22b. SIGNATURE Charles R. Graham Jr.		22c. DEGREE no		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 299 Frederick Rd Balt Md 21228				22f. DATE SIGNED 8/3/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Sept. 1, 1985		23c. NAME OF CEMETERY OR CREMATORIAL Security Process. Inc. Catonsville, Balto. Md. 21225		23d. LOCATION CITY OR TOWN -----		COUNTY -----	STATE -----				
24. FUNERAL DIRECTOR McCurry Funeral Home, 237 E. Patapsco Ave.		25a. ADDRESS -----		25b. DATE REC'D. BY REGISTRAR SEP 4 1985		25c. REGISTRAR'S SIGNATURE Charles R. Graham Jr.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

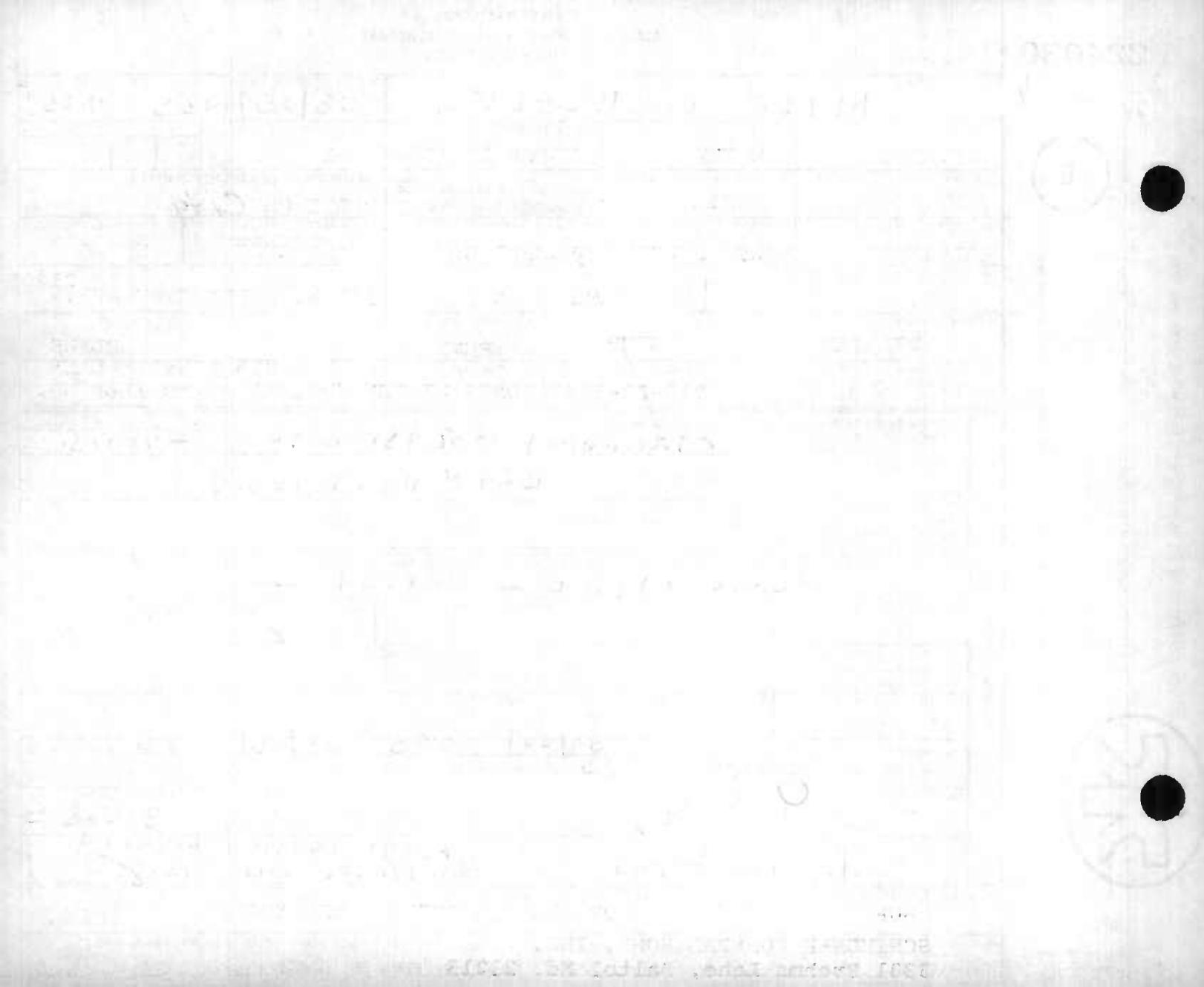
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST HELEN	MIDDLE C	LAST WEBER	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
						MARCH	15	1904	08	05	1985	7.25 P.M.
3. SEX			4. RACE		5. DATE OF BIRTH	6. AGE IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR			
FEMALE			WHITE		MONTH DAY YEAR MARCH 15 1904	81	IF UNDER 24 HRS		MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City			MD.			
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS			12b. KIND OF BUSINESS OR INDUSTRY SEWING				
13a. STATE MD.			13b. COUNTY BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 941 N. COLLINGTON AVE.			21205	
14. FATHER'S NAME FIRST WILLIAM			MIDDLE 308	LAST WEBER	15. MOTHER'S MAIDEN NAME FIRST EMMA			MIDDLE HULFUS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 213-03-3597		17. INFORMANT DORIS HICKEY (NIECE)			ADDRESS 215 LINCOLN LANE SYKESVILLE MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA - BREAST WITH DUE TO, OR AS A CONSEQUENCE OF BRAIN METASTESIS - years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RENAL FAILURE - UREMIA												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 07/20 , 19 85 , to 08/05 , 19 85 , that (I) (we) last saw the deceased alive on 08/05 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>S. Schmitz MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED 8/15/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur A. MD			22e. ADDRESS NORTH CHARLES HOSPITAL BALTIMORE, MD 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/8/85		23c. NAME OF CEMETERY OR CREMATORIAL MORELAND MEMORIAL	23d. LOCATION BALTIMORE		COUNTY	STATE MD.			
24. FUNERAL HOME NAME SCHMUNEK FUNERAL HOME, INC.			ADDRESS 3331 Brehms Lane, Balto. Md. 21213		25a. DATE REC'D. BY REGISTRAR AUG 8 1985			25b. REGISTRAR'S SIGNATURE <i>John Pendle</i>				



227073

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

2215

1. DECEASED NAME (TYPE OR PRINT)			FIRST MARY	MIDDLE WEEKS	LAST	2d. DATE OF DEATH AUGUST 9, 1985	MONTH YEAR	2b. HOUR 05:38 pm	
3. SEX Female		4. RACE Negroid	5. DATE OF BIRTH MONTH 7 DAY 10 YEAR 10			6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY	
13. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1525 E. Preston St. 21213	
14. FATHER'S NAME FIRST FRED		MIDDLE Johson	LAST	15. MOTHER'S MAIDEN NAME FIRST Willie			MIDDLE Jackson	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES GIVE WAR OR DATES) 217-07-0845		17. INFORMANT FRIZZELL WEEKS			ADDRESS 5550 Chateau Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ischemic Cardiomyopathy</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0 - 5 mins.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Anemia</u>									2-3 hours
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) saw the deceased alive on 8/9 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/9 1985 to 8/9 1985 , that (I) (we) last saw the deceased alive on 8/9 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									22c. DATE SIGNED 8/9/85
22b. SIGNATURE Steve D. DaTorre		22c. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steve DaTorre		22e. ADDRESS JHH 601 W. Wolf St Balto. Md 21205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-16-85		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cemetery Anne Arundel County, MD		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Calvin B. Scroggs		ADDRESS 1412 E. Preston St.		25a. DATE REC'D. BY REGISTRAR AUG 13 1985		25b. REGISTRAR'S SIGNATURE Julia Dawson			

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified, it may be filed in the funeral director's records. Page 3 should be detached for use as the burial permit. Then please return page 1 and page 2 to the medical examiner. If you have any questions concerning this form, contact the State Dept. of Health and Mental Hygiene, Bureau of Vital Statistics, 201 W. Preston Street, Baltimore, Maryland 21201.

RELEASED NON-MEDICAL DR. RAUFFMAN PER

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper from pages 2 and 3. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical certifying physician must be identified at once.

242073

22/52

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
James E. Weldon						8/27/85			1985	11:20 PM
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				
Male		Black	MONTH	DAY	YEAR	69	IF UNDER 1 YEAR	MONTHS	IF UNDER 24 HRS	
			TAN.	30	1916	7	YEARS	28	HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?	8			9 BALTIMORE CITY OR COUNTY OF DEATH				
SC		USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore City				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY
Baltimore		Mercy Hosp			Businesswoman					MD.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS ZIP CODE		
MD			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1008 Tiffany Ct 21207		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	
Donald W. Weldon					DANIELIA		W.	C.	1916	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
(If Yes, give War or Dates)		24814 2915			Addie J. Burt 2025 K. Ave. BW					
18. CAUSE OF DEATH (Enter only one cause per line for Part I) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Allergic Severe Reaction (Anaphylactic and Epidermal) to 9478								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
										20 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Administration of Antibiotic (Ancef)								
		(c) Infection prevention following Kidney operation (ureterolithotomy)								circumcision +
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
Prostate Cancer, Kidney stones (E. coli infection, E. coli septicemia)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
8/7/85		above			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from Aug. 6, 1985, to Aug. 27, 1985, that (I/we) last saw the deceased alive on Aug. 27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We did / did not) view the body after death.										
22b. SIGNATURE		DEGREE			22c. DATE SIGNED					
Thomas J. O'Leary MD.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			8/28/85 12:15 PM					
22d. PHYSICIAN'S NAME		22e. ADDRESS								
Thomas J. O'Leary		Mercy Hospital, Baltimore, MD.								
23a. BURIAL, CREMATION, REMOVAL (CHECK)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ESTATE		23d. LOCATION CITY OR TOWN		23e. STATE		
Burial		8/31/85		Mt Calvary		Baltimore MD		21207		
24. FUNERAL DIRECTOR		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Terry Hayes 638 N Calmon					AUG 28 1985		Gloria Davidson Pendleton			
DHMH - 16 60M 7/84 (VRA 15, 4)										

256070

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 2, 3 AND 4 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 2 AND 3 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
EMILY			J.	WEST		X 8-31-9-1985	MONTH	DAY	YEAR	2d HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	9 4	1985	4P M	
Female	Black	2/16/34				Baltimore City				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH	MD.				
Pitts. Pa.		USA			Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		3308 N. Hilton St.				Clerical		U.S. Govn.		
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3308 N. Hilton St. 21216					
14. FATHER'S NAME FIRST J. W.		MIDDLE Ross	LAST	15. MOTHER'S MAIDEN NAME FIRST Lula	MIDDLE Cook					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-32-1937	16c. INFORMANT Grace Wallace 3631 Coronado Rd. 21207							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: - IMMEDIATE CAUSE (a) <u>Multiple stab wounds</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause lost.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8-31-9-1985		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject stabbed.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET 3308 N. Hilton St., Balto.		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER						
Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/9/85		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cem.		23d. LOCATION CITY OR TOWN Baltimore		COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Chas.A.Rice FSPA		ADDRESS 1300 Eutaw Place		25a. DATE REC'D. BY REGISTRAR SEP 10 1985		25b. REGISTRAR'S SIGNATURE				
D�MH - 17 (VR A15 ME (5))										

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DEATH	MONTH	DAY	YEAR	2b HOUR			
Paul			L.	West		August 28, 1985				M			
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White	Sept. 20 1926			58		MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City							
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) 337 S. Newkirk Street			12a. USUAL OCCUPATION (Type of work for most of working life) Laborer								
13a. STATE Md.		13b. COUNTY	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 337 S. Newkirk St. 21224		12b. KIND OF BUSINESS OR INDUSTRY Steelworker				
14. FATHER'S NAME John		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Ida									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT Audrey V. West 337 S. Newkirk St.			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>I.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, street, factory, office, farm, etc.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1977</u> 19 to <u>8/23</u> 19, that (I) (we) lost sow the deceased alive on <u>8/23</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>8-29-88</u>	
22b. SIGNATURE <u>Morton C. O'Brien</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Morton C. O'Brien</u>		22e. ADDRESS <u>2936 E. Baltimore St</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-30-85		23c. NAME OF CEMETERY OR CREMATORIUM Westview Crematorium			23d. LOCATION CITY OR TOWN Balto.		COUNTY	STATE Md			
24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc.		ADDRESS 401 S. Chester St.			25a. DATE REC'D. BY REGISTRAR AUG 30 1985			25b. REGISTRAR'S SIGNATURE <u>John M. Weber & Sons Inc.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 & 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22 / 55							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d HOUR							
DOLORES					WHIDBEE	8-9-85						12:20 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		Black		MONTH	DAY	YEAR	78 YRS.			MONTHS	DAYS	HOURS	MIN.						
10a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Maryland		U. S. A.					Baltimore, city												
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12d. INSIDE CITY LIMITS?			12e. STREET ADDRESS / ZIP CODE			12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		Lutheran Hospital		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			740 Poplar Grove Apt. 1-L			21216									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
Maryland				Baltimore															
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
James		P.		Whidbee	Annie						Shirley Charlton 740 Poplar Grove			Tate					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. IF YES, GIVE WAR OR DATES		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
No																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												Cardiogenic shock							
(b) Acute Myocardial Infarction																			
(c) ASCVD																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/2, 1985, to 8/9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE BICH T DUONG												DEGREE M.D.	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/9/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			LUTHERAN HOSPITAL														
Burial		Arbutus Memorial Park			Arbutus, Maryland														
24. FUNERAL DIRECTOR NAME Bailey-Douglass Funeral Home		ADDRESS 1348 N. Calhoun St.			25a. DATE REC'D. BY REGISTRAR AUG 14 1985														
25b. REGISTRAR'S SIGNATURE Lisa Trinidad-Pendell																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22156

1. DECEASED NAME (TYPE OR PRINT)			FIRST ANNIE	MIDDLE E.	LAST WHITE	2a. DATE OF DEATH MONTH August 19, 1985	DAY YEAR	2b. HOUR 9:30 A.M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Oct. 29, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 91		IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? England		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3030 Guilford Avenue		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. STATE MD		13b. COUNTY Baldo.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3030 Guilford Ave., 21218				
14. FATHER'S NAME FIRST Jack		MIDDLE Eggs		15. MOTHER'S MAIDEN NAME FIRST Harriet		MIDDLE LAST Dearling				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215 96 4120		17. INFORMANT Mrs. Doris Smigaj,		ADDRESS Same				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sev. month				
DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic cardiovascular disease						many years				
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (his/hospital) attended the deceased from 11-25 1957 to 8-19 1985 , that (I) <input type="checkbox"/> lost saw the deceased alive on 4-17 1985 and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <i>Alfred G. Ossman, MD</i>		22c. DEGREE				22d. DATE SIGNED 8-20-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Alfred G. Ossman, MD		22e. ADDRESS 1101 St. Paul St., Balto., MD 21202								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/21/85		23c. NAME OF CEMETERY OR CREMATORIAL Moreland Memorial		23d. LOCATION CITY OR TOWN Balto. County, MD		STATE		
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co. ADDRESS 4905 York Road Balto., MD 21212		25a. DATE REC'D. BY REGISTRAR AUG 21 1985				25b. REGISTRAR'S SIGNATURE <i>John Davidson Pendell</i>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by you, it should be retained for use as the burial transit permit. Then please check "Yes" prior to burial cremation or removal. If item 21 is marked "No", then the State Dept. of Health and Mental Hygiene will not receive notification of death.

IMPORTANT: If item 21 is marked "No", then the State Dept. of Health and Mental Hygiene will not receive notification of death.

1 - STATE REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
CHASITY N WHITE						AUGUST 10. 1085				02:17 am			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
female		white		June 26, 1985			<input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			YRS. 13			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY			
Maryland		usa											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.			
BALTIMORE		THE JOHNS HOPKINS HOSPITAL		none									
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21661	
13b. STATE		13c. COUNTY		Rock Hall			Rte 2 Bx 121B						
Maryland		Kent											
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			Patterson					
James Noble White					Evonne								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			Rte # 2 Box 121B				
no			none			Evonne White Rock Hall, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR UNRESPONSIVENESS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min													
DUE TO, OR AS A CONSEQUENCE OF (b) HYPOTENSION LOW CARDIAC OUTPUT 6 hrs													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) POST OP REPAIR TRANSPOSITION ARTERIES 5 wks													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
8-9-85		TRANSPOSITION GREAT ARTS VSD			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (this hospital) attended the deceased from 8-9-85 to 8-10-85, the (1) two lost saw the deceased alive on 8-10-85 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I was not present at the time of death.)													
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 8-10-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			600 N WOLFE ST BALTO, MD 21205 THE JOHNS HOPKINS HOSPITAL					
Burial		23b. DATE 8/12/85			23c. NAME OF CEMETERY OR CREMATORIAL Saint Paul's Cem. Near Rock Hall, Md. 21661			23d. LOCATION CITY OR TOWN					
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Willis Wells		Chesertown, Md.			AUG 14 1985			Julia Davidson-Bendell					

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**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

**1 - STATE
REGISTRAR**

REG. NO.

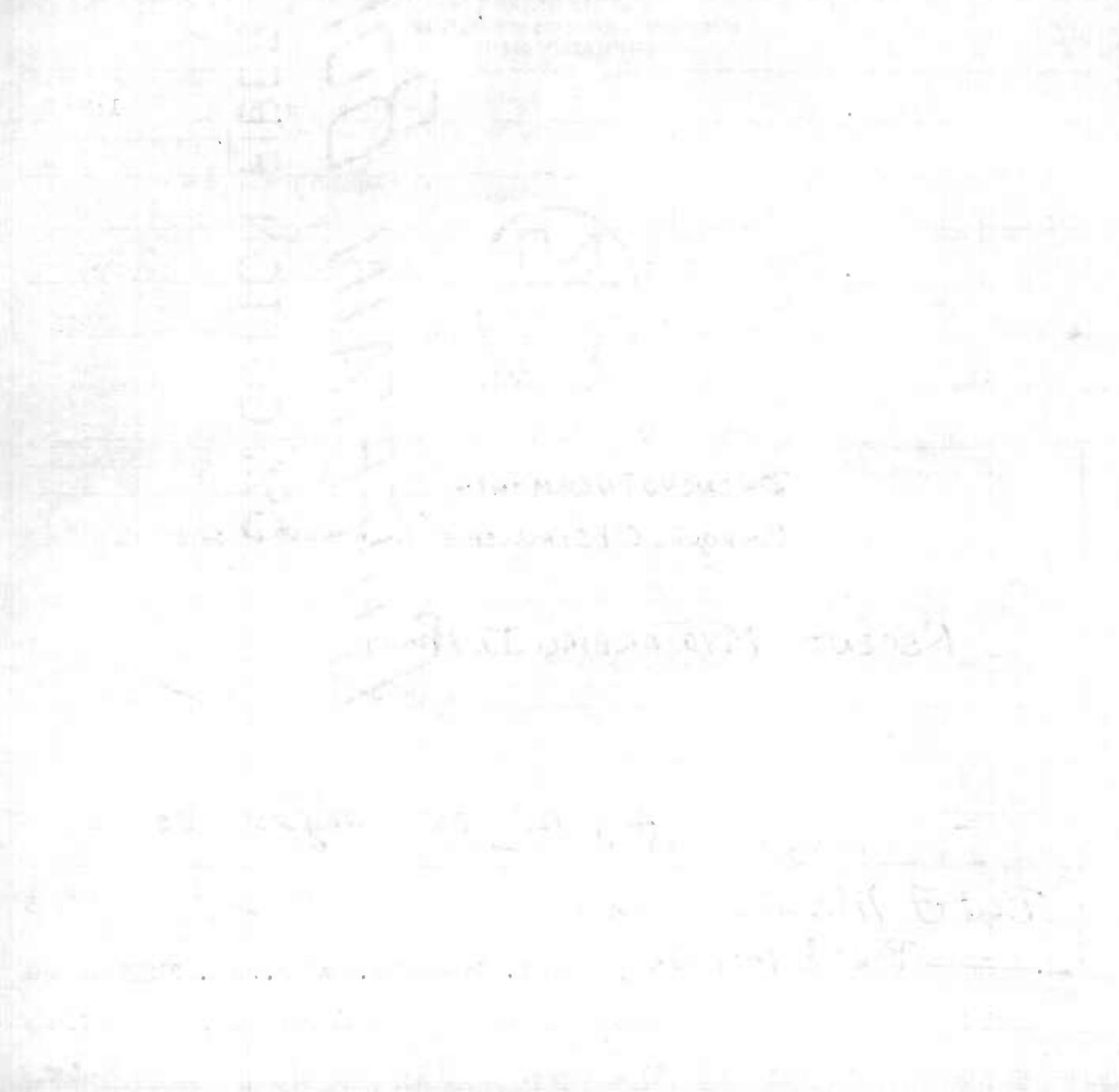
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
EDWARD			W.		WHITE	AUGUST	25,	1985		1:20 PM
3. SEX		4. RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)				
MALE		WHITE	MONTH	DAY	YEAR	71				
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.					Baltimore City MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		ST. AGNES HOSPITAL			Truck Drive		City of Baltimore			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Maryland				Baltimore				2901 Kingsley Street 21223		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	Unavailable
Unavailable				White	Lillian					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS			
No		213-05-8603			William E. White 504 Hurley Ave. 21223					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CHRONIC ObSTRUCTIVE Pulmonary Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
<u>RECENT MYOCARDIAL INFARCT</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (this hospital) attended the deceased from <u>Aug. 12, 1985</u> to <u>Aug. 25, 1985</u> that (we) last saw the deceased alive on <u>Aug. 25, 1985</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> did not view the body after death.										
22b. SIGNATURE <u>Bert F. Morton</u>		DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/25/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR. MALLATRA</u>		22e. ADDRESS 900 So. Caton Ave. Balt., Md. 21220								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8/29/85		23c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer		23d. LOCATION CITY OR TOWN Baltimore		COUNTY	STATE Maryland	
24 FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC.		ADDRESS 4107 Wilkens Ave.			25a. DATE REC'D. BY REGISTRAR AUG 28 1985		25b. REGISTRAR'S SIGNATURE <u>Linda Henderson Pendleton</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from us as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical

STATE OF MARYLAND - DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 22159	
1 - STATE REGISTRAR			20. DATE OF DEATH MONTH DAY YEAR 08-01-85							26. HOUR	
1. DECEASED NAME (TYPE OR PRINT) GEORGE			MIDDLE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 01-08-1911			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		
3. SEX MALE			4. RACE BLACK			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA			7b. CITIZEN OF WHAT COUNTRY? USA			8. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1821 W. FAYETTE STREET			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND			13b. COUNTY BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1821 W. FAYETTE STREET 21223		
14. FATHER'S NAME FIRST JAMES			MIDDLE WHITE			15. MOTHER'S MAIDEN NAME MAGGIE					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. 717-07-9602			17. INFORMANT LAWRENCE HENLY			ADDRESS 3603 HOWARD PARK AVE.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF SEVERE CHRONIC OBSTRUCTIVE PULMONARY DISEASE											
(c) DUE TO, OR AS A CONSEQUENCE OF LUNG CARCINOMA											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a.1. I certify that (I) (has) attended the deceased from 1985, to 1985, and that in my opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.											
22b. SIGNATURE HOWARD B. CHEN, M.D.			DEGREE			22c. DATE SIGNED 8/2/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOWARD B. CHEN, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS BON SECOURS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/5/1985			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn Cem			23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE		
24. FUNERAL DIRECTOR NAME Brown/ Thompson F. H.			ADDRESS 19113 W. Balto. St.			25a. DATE REC'D. BY REGISTRAR AUG 02 1985			25b. REGISTRAR'S SIGNATURE Julie Turidson Pendell		

221081

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGES 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

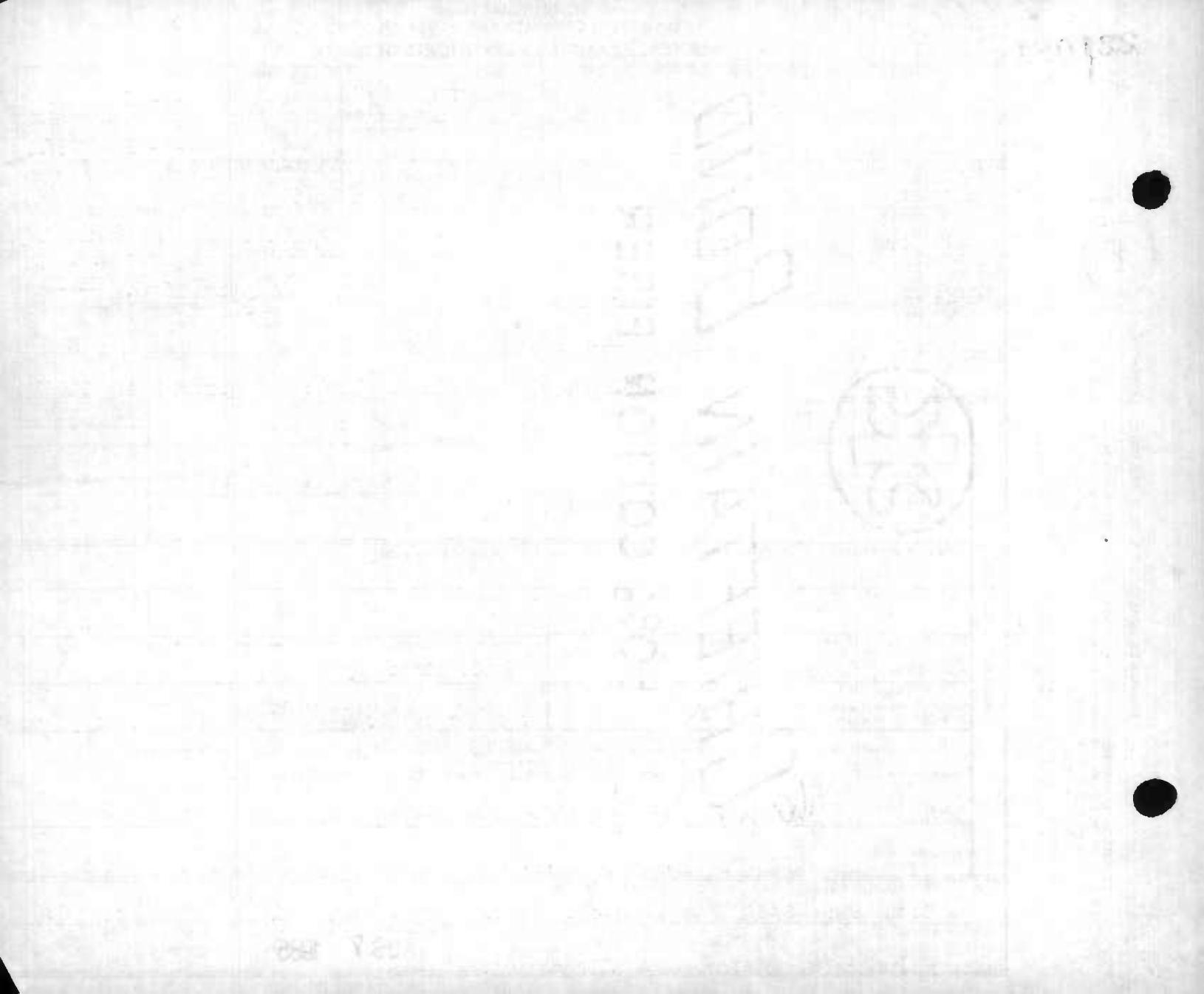
1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22160

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
			WILLIAM	JEROME	WHITE	<input checked="" type="checkbox"/>	8-2-85	19	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
Male	White	Jan. 6 1915	70 yrs.			8-2-85	19	9AM	M	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore		University Hospital			Laborer			Housekeeping For N.H.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS				
Maryland			Baltimore		YES <input checked="" type="checkbox"/>	1111 Washington Blvd. 21230				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST			
James			White	Elizabeth			Leonard			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/a			16b. SOCIAL SECURITY NO. 212-16-2426			17. INFORMANT Jessie E. Wlasic 115 Vernon Ave. 21061			ADDRESS	
PART 1 DEATH WAS CAUSED BY: 8147 IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6AM P.M. 8-2-85 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject struck by an auto						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hwy.		21f. LOCATION STREET M. Martin Luther King Blvd CITY OR TOWN COUNTY STATE Baltimore, Maryland						
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion							
ACTUAL SIGNATURE Margarita Korell, M.D.			TITLE (SPECIFY) Assistant M.D.			MEDICAL EXAMINER			DATE SIGNED 8-2-85	
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Cremation 8/4/85		23c. NAME OF CEMETERY OR CREMATORIAL Security Process Crem.			23d. LOCATION CITY OR TOWN Catonsville		COUNTY Baltimore	STATE Md.
24. FUNERAL DIRECTOR NAME		ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR AUG 7 1985			25b. REGISTRAR'S SIGNATURE John D. Smith			
DHMH - 17 (VR A15 ME (5))										



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Film G609 item 5&6
FOR
STATE 11/15/805 rja
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2216

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
WOODROW WILSON WILKINS						AUGUST 17, 1985	X	X	X	7:30 a.m.	
3 SEX	4 RACE	5. DATE OF BIRTH			MONTH	DAY	YEAR				
Male	Black	9 20 21			9	22	21				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
VA	USA						63	64	YRS.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Church Home Hospital								
13a. STATE MD			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
									13e. STREET ADDRESS / ZIP CODE 2212 E. Fayette St. 21231		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST		
Paul			Wilkins			Sarah			Hendrick		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
Yes			224-26-5972			Mabel Wilkins			2212 E. Fayette St.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA											
DUE TO, OR AS A CONSEQUENCE OF (c) SEPSIS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) X DEMENTIA											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from AUGUST 6, 1985, to AUGUST 17, 1985, that (I) (we) last saw the deceased alive on AUGUST 17, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR		STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8-17-85
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					ADDRESS			CHURCH HOSPITAL 100 N. 8th Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/23/85		23c. NAME OF CEMETERY OR CREMATORIAL Garrison Forest VA			23d. LOCATION OWINGS Mills		23e. COUNTY MD STATE		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.			25a. DATE REC'D. BY REGISTRAR AUG 22 1985			25b. REGISTRAR'S SIGNATURE Fisher Anderson Pendell			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy (page 2) and file with 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached to use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above, any injury or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
<i>Boy</i>					<i>Williams</i>	<i>7/28/85</i>				<i>11 A.M.</i>			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
<i>Male</i>		<i>Black</i>		<i>7/24/85</i>			<i>1 day</i>			<i>1</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVERMARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			CITY			
<i>Mo</i>		<i>US</i>											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>Baltimore City</i>		<i>UNIV OF MD HOSPITAL</i>					<i>N/A</i>			<i>N/A</i>			
13a. STATE 13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS / ZIP CODE			<i>21401-713 E Newhouse Dr Annapolis</i>			
<i>MD</i>		<i>Balt City</i>		<i>Baltimore</i>									
14. FATHER'S NAME FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME									
<i>W.H.</i>				<i>MILDRED</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS						
<i>No</i>													

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

*RESPIRATORY FAILURE*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) *PREMATURITY (NON VIABLE)*

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

PNEUMOTHORAX, HYPERTENSION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
<i>7/25/85</i>	<i>PNEUMOTHORAX</i>	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOT MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)
<i>NA</i>	<i>NA</i>	<i>NA</i>

21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT HOME <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	<i>NA</i>	<i>Na</i>			

22a. I certify that (I) (this hospital) attended the deceased from <i>7/24/85</i> , 19_____, to <i>7/24/85</i> , 19_____, that (I) (we) last saw the deceased alive on <i>7/24/85</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
---	--	--	--	--	--

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
<i>L. J. Gopalakrishnan MD</i>			<i>7/25/85</i>

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
<i>L. J. GOPAL MD</i>	<i>UNIV OF MD 1000 SICU</i>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM	23d. LOCATION CITY OR TOWN	23e. COUNTY	23f. STATE
<i>REMOVAL</i>	<i>8/8/85</i>				

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
<i>Hospital太平间</i>		<i>AUG 16 1985</i>	<i>Julia Davidson Pendleton</i>

710265

246072

1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22763

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3 RETAIN PAGE 3 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST ALVIN	MIDDLE A.	LAST WILLIAMS	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 8-23-85	DAY 19	YEAR	2b. HOUR M	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH 10	DAY 16	YEAR 59	6 AGE (IN YEARS LAST BIRTHDAY) YRS. 25	7 IF UNDER 1 YR. MONTHS 0	8 IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 8-23-85		MONTH 19	DAY 12PM	YEAR M
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 5428 Jonquil Ave. 21218					
14. FATHER'S NAME FIRST James		MIDDLE Brown	15. MOTHER'S MAIDEN NAME FIRST Doris		MIDDLE 	LAST Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-66/5504		17. INFORMANT Doris English		ADDRESS 1633 Ramblewood Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple gunshot wounds DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR 6:39 PM		MONTH 8-23-85	YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) store		21f. LOCATION 4507 Belair Road		ITY OR TOWNE Baltimore STATE Maryland				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
ACTUAL SIGNATURE <i>Margarita A. Korell</i>		TITLE (SPECIFY) Assistant		M.D.		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.										DATE SIGNED 8-24-85
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/30/85		23c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		23d. LOCATION CITY OR TOWN Baltimore		COUNTY MD	STATE	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR AUG 29 1985		25b. REGISTRAR'S SIGNATURE <i>R. Davidson Pendleton</i>				

550000

930-401303 NO

CHARGE WIRELESS

246088

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED IN PENCIL IN ITEM 1b, GIVE PENCIL TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM BM 3 RETAIN PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL AND IT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL CREMATION OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22764
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
Carl			D.		Williams, SR,	<input type="checkbox"/>			8/26/1985			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
MALE	BLACK	JAN. 27 1957 28	YRS.	MONTHS	DAYS	8/26/1985				12:10 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND		U.S.A.						Baltimore City,				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		University Hospital Shock Trauma			CONSTRUCTION WORK			RAILROAD				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS					
MARYLAND		HARFORD	EDGEWOOD				1841 EDGEWATER DRIVE 21040					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. ADDRESS				
CHARLES				WILLIAMS	MARY			EDGEMEAD, MARYLAND 21040				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			VIVIAN A. TRAFTON, 1713 MELWOOD COURT				
No		213-68-2067										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8150 IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 11:00 A.M. 8/25/85			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subj. driver of auto/lost control						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET CITY OR TOWN Old Post Rd. & Rt. 22, Harford Co., Md.			CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE _____ TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE		
BURIAL		30 AUG. 1985		Holly Hill Mem. Gardens		Middle River		Baltimore		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
TAKING FUNERAL HOME, P.A., ABERDEEN, MD. 21399		21001		AUG 29 1985								
DHMH - 17 (VR A15 ME (5)) 20M 4/B2												

220015



232065

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22765

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
EDNA WILLIAMS				AUGUST 12, 1985				3:45pm			
3 SEX 4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Female Black		10 10 01		83		YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH AGENCY, GIVE STREET ADDRESS) Church Home Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 319 S. Herring Ct. 21231			
14. FATHER'S NAME FIRST MIDDLE LAST John Hathaway		15. MOTHER'S MAIDEN NAME -		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-14-1990		17. INFORMANT Mary Taylor 330 S. Herring Ct.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CEREBROVASCULAR ACCIDENT						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF							
		(c)		DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7-28, 19 85, to 8-12, 19 85, that (I) (we) last saw the deceased alive on 8-12, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22g. DATE SIGNED 8/12/85	
22b. SIGNATURE <i>A. F. Nazemi MD</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 8/12/85					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. F. NAZEMI MD.		22f. ADDRESS Church Hospital 100 North Broadway Baltimore, Md 21231									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/16/85		23c. NAME OF CEMETERY OR CREMATORIAL Eastview Memorial Pk.		23d. LOCATION CITY OR TOWN Baltimore		23e. COUNTY		23f. STATE MD	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H		ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR AUG 15 1985		25b. REGISTRAR'S SIGNATURE <i>Davidson Pendell</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-trust permit. Then please attach this certificate to the death record in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

20050



232088

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22760

E0219068

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed at once.

1 - STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
			EUGENIA WILLIAMS			8/16/85			10:18 P				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS				
Female		Black		8/16/18		66			IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			BALTIMORE CITY MD.				
NORTH CAROLINA		U.S.A.				BALTIMORE CITY							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE		ST. AGNES HOSPITAL		HOMEMAKER									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13c. STREET ADDRESS / ZIP CODE							
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5 S. ABINGTON AVENUE, 21229				
14. FATHER'S NAME FIRST DANIEL		MIDDLE		LAST SIMONS		15. MOTHER'S MAIDEN NAME FIRST HATTIE			LAST EVANS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-16-3851		17. INFORMANT FRANK WILLIAMS, 5 S. ABINGTON AVENUE			ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anet Myocardial Infarction</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Systemic Lupus Erythematosus</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
YES <input type="checkbox"/> NO <input type="checkbox"/>						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6/19/83</u> to <u>8/19/85</u> , that (I) (we) last saw the deceased alive on <u>July 19 85</u> , and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>M. Kahan MD</i>		DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/19/85</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>M. Kahan MD</i>		22e. ADDRESS <i>2717- HAMMONS FERRY RD 21229</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/15/1985		23c. NAME OF CEMETERY OR CREMATORIAL EXPRESS INC. Meadow Ridge Mem. Pk.		23d. LOCATION CITY OR TOWN HOWARD COUNTY		24. FUNERAL DIRECTOR NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PARKWAY				25a. DATE REC'D. BY REGISTRAR AUG 15 1985	
25b. REGISTRAR'S SIGNATURE <i>in Division Pending</i>													

238128

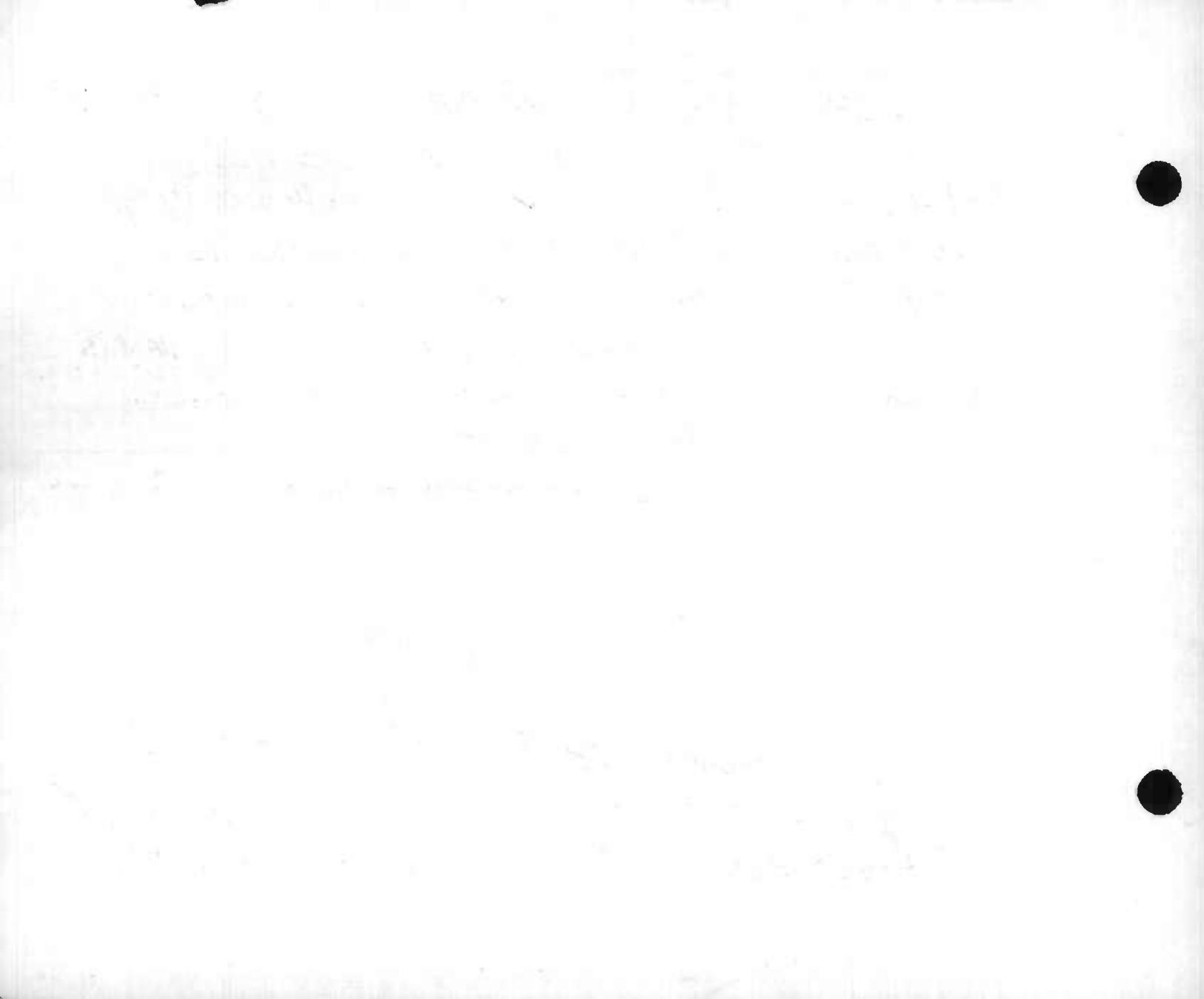
be satisfied within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. They please remove carbon copy. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner shall be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22761								
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE		LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR				
Hyman							Williams			8	9	85	5:33 P.M.					
3. SEX		4. RACE					5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR				
m		B					MONTH DAY YEAR			55				MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.				
83 Park U.S.A.		U.S.					12 15 29			Baltimore City								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore		John Deaton Medical Center					Auto Mechanic											
13a. STATE		13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE								
MD.					Baltimore		YES			1706 E. 33rd St. 21218								
14. FATHER'S NAME FIRST		MIDDLE			LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE				LAST				
Unknown					Williams		LAURA							HARRIS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
(YES, NO OR UNKNOWN)		215-24-8230			Ms. Catherine Wright Balto., Md.			1023 Rutland Ave.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest																		
DUE TO, OR AS A CONSEQUENCE OF (b) Lung Cancer metastatic to brain																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from April 5, 1985, to August 1, 1985, that (I) (we) last saw the deceased alive on August 9, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE James H Zenis MD																		
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							22f. DATE SIGNED 8-12-85									
James H Zenis MD		120 S Greene St. Baltimore Md																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE						
Removal		8/9/85																
24. FUNERAL DIRECTOR NAME		ADDRESS							25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Anatomy Board		Balto., Md.							AUG 21 1985		Levierson Pendell							



246136

22 / 68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST JULIUS	MIDDLE WILLIAMS	LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
3 SEX			4 RACE		5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Black		MONTH	DAY	YEAR	59	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
N.C.			USA						BALTIMORE CITY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE			VA MEDICAL CENTER BALTIMORE MD										
13a STATE Md.			13b COUNTY		13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1010 Stoddard Ct. 21201				
Balto.													
14. FATHER'S NAME FIRST Charlie			MIDDLE Williams		LAST			15. MOTHER'S MAIDEN NAME FIRST Anna	MIDDLE Perry		LAST		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
yes Korea			245 20 1824		Virginia Williams			1315 N. Patterson Pk Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Who saysis Jurema												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic renal failure.													
DUE TO, OR AS A CONSEQUENCE OF (c) Kimmelstiel Wilson's Disease of kidney.													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 1, 19 85, to August 21, 19 85, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 21, 19 85, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.												22c. DATE SIGNED 8/2/85	
22b. SIGNATURE A.J. ROMANSKY		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.J. ROMANSKY MD		22e. ADDRESS 3900 Loch Raven Blvd. Baltimore Md 21218											
23a BURIAL, CREMATION, REMOVAL Burial		23b DATE 8-27-85		23c NAME OF CEMETERY OR CREMATORIAL Garrison Vet. Cem.		23d LOCATION CITY OR TOWN Reisterstown, B.C. Md.		COUNTY		STATE			
24 FUNERAL DIRECTOR NAME Charles A. Rice FSPA 1300 Eutaw Pl ,				25a DATE REC'D. BY REGISTRAR AUG 30 1985		25b. REGISTRAR'S SIGNATURE Julie Davidson-Randall							
RECORDED BY THE HOSPITAL OR ATTENDING PHYSICIAN													
10. FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transfer permit. Then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial transfer permit. Then please remove carbon paper. Pages 3 and 4 may be used for the funeral director. Item 21 should be filled in within 72 hours after death.													
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.													
RECORDED BY THE HOSPITAL OR ATTENDING PHYSICIAN													

RECORDED BY THE HOSPITAL OR ATTENDING PHYSICIAN

10. FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transfer permit. Then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial transfer permit. Then please remove carbon paper. Pages 3 and 4 may be used for the funeral director. Item 21 should be filled in within 72 hours after death.

stage

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be continued.

220067

1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22169

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MAYBEL S WILLIAMS						8/1/85				2:55 P.M.	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		B	MONTH	DAY	YEAR	86	IF UNDER 24 HRS		MONTHS	DAYS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		USA						Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		LUTHERAN HOSPITAL			Homemaker			AT HOME			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MD			Baltimore, MD 21217					1837 DAVIDSON AVE 21217			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Daniel Taylor					Betty Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO		418-07-2177-3			Doris Carter 222 SURGEON RD 21228						
18. CAUSE OF DEATH (Enter only one cause per line for item (b) and PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
CARB RESPIRATORY OBST											
DUE TO, OR AS A CONSEQUENCE OF (b)											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
19b. YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)						
21b. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21d. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (1) (this hospital) attended the deceased from _____ to _____, 19_____, that (1) (we) lost saw the deceased alive on _____ to _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			8/1/85			
LETICIA CUETO					LETICIA CUETO						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL MATERIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE			
Burial		8-5-1985		Mt Calvary		Baltimore, MD 21225					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Thomas J. Mulligan 638 W. G. Linnell St.		AUG 6 1985			John Davidson-Randall						

60700

246135

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22170

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Marquette Margaret Williams</i>						8	23	85	4:05 PM		
3. SEX	RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.		
FEMALE	B	3 21 26				59					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
N. Carolina	U.S.					B. City					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION. 12b. KIND OF BUSINESS OR TYPE OF WORK FOR MOST OF WORKING TIME INDUSTRY					
B. City	Univ HCSB					BALTO. CO. GEN. HOSP-NURSE ASST.					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE				
Md	Balto	Balto					4314 KATHLAND AVE. 21207				
14. FATHER'S NAME	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				MIDDLE	LAST	ADDRESS		
David		Williams	Vera				Russell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO	217-20-4717					Jimmie Burton					min
(b) Liver Failure											1wk
(c) Acute lymphoblastic leukaemia											1yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/23 , 19 85 , to 8/23 , 19 85 , that (I) (we) last saw the deceased alive on 8/23 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>K Snyder MD</i>	DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 5/27/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>K Snyder</i>	22e. ADDRESS 22 S Greenup St				22f. ADDRESS 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8-29-85	23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND NAT. MEM. PK. BALTO. MD.				23d. LOCATION CITY OR TOWN	... COUNTY STATE ..			
24. FUNERAL DIRECTOR LEROY O. DYETT 4600 LIBERTY HGTS AVE.	ADDRESS					25a. DATE REC'D. BY REGISTRAR AUG 30 1985	25b. REC'D. BY STAFF MD				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be filed by the funeral director, page 3 should be detached for use as the burial/cremation permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)

WILSONS

WILSONS → Sharpbill

PC 915 E

(108) X 20 and 20

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brown

white brown black

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233135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate and removed. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

2271

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST Ora B. Williams	MIDDLE	LAST	20. DATE OF DEATH Aug 15, 1985	MONTH	DAY	YEAR	2b. HOUR	
3. SEX Female			4. RACE Black		5. DATE OF BIRTH MONTH 3/31/1895 DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 90	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Evans, Ind.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City					
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3124 Windsor Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife			12b. KIND OF BUSINESS OR INDUSTRY --- O ---			
13a. STATE Md			13b. COUNTY -----		13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3124 Windsor Ave. 21216				
14. FATHER'S NAME FIRST Luther Owens			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Ella Woodard			MIDDLE	LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) -----			16b. SOCIAL SECURITY NO. -----		17. INFORMANT Jerome Williams, 3124 Windsor Ave. 21216			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
			DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	1b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-31-85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE James J. McPhillips		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 8/17/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5550 Baltimore National Pike, Balto, MD 21228									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/20/85		23c. NAME OF CEMETERY OR CREMATORIAL Mt Calvary Cemetery			23d. LOCATION CITY OR TOWN Baltimore, Maryland				
24. FUNERAL DIRECTOR NAME Law Funeral Funeral		ADDRESS 3611 Park Ave. 21215		25a. DATE REC'D. BY REGISTRAR AUG 19 1985			25b. REGISTRAR'S SIGNATURE John Davidson Pendell				

201-88

Q81.11.100

Q81.11.100

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Q81.11.100

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Q81.11.100

Counting

all work

Mr. Yoshida, M.D.

unpublished

Q81.11.100

Counting

lymphatic

new table

Q81.11.100

Scans of the slide and it should be
transferred without leaving any marks

Q81.11.100

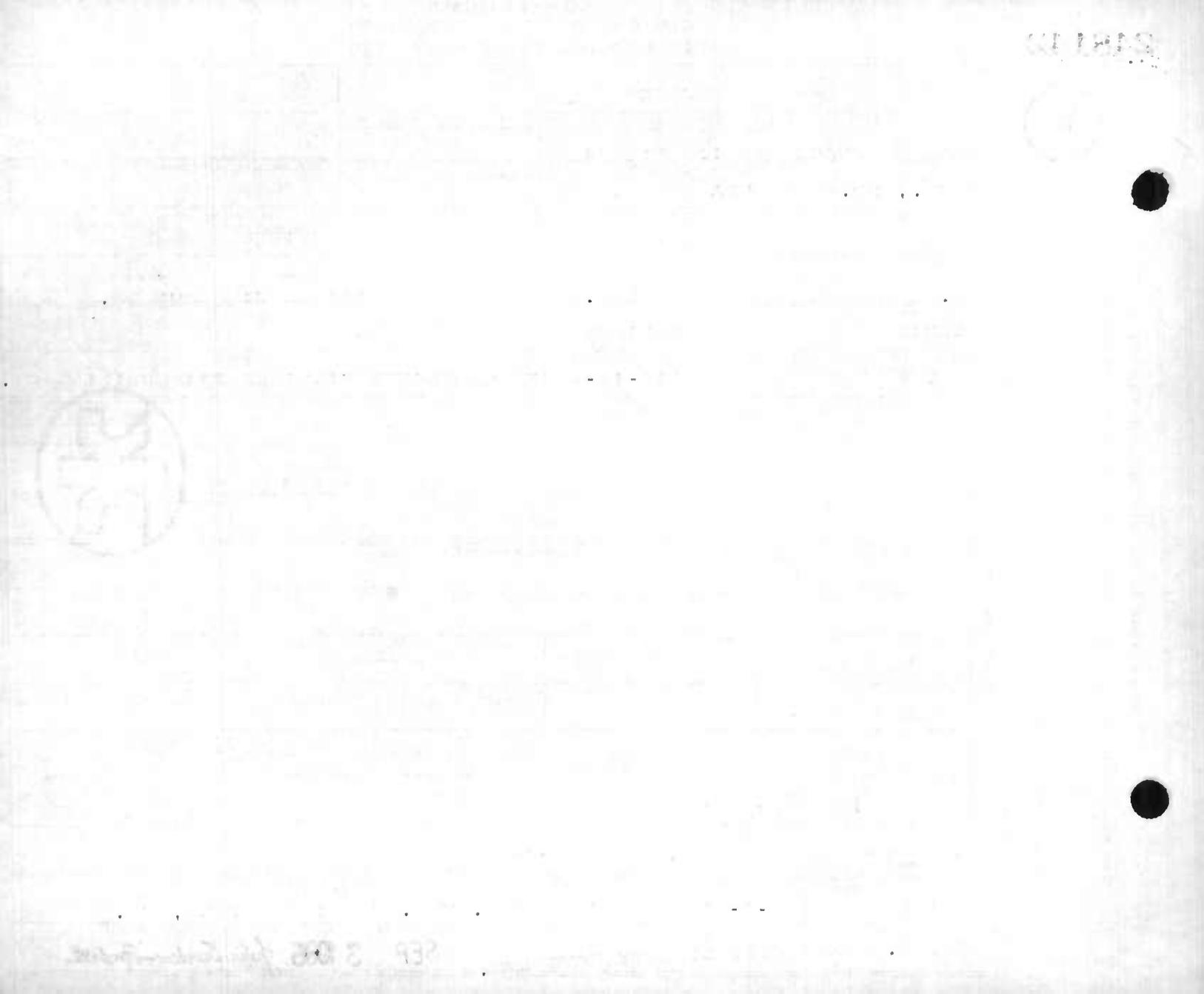
248142

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 16, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED IN WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												22 / 72				
												REG. NO.				
1- FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- MATED	MONTH	DAY	YEAR	2b. HOUR
I. DECEASED NAME (TYPE OR PRINT)			OSBOURNE			JAMES			WILLIAMS			<input checked="" type="checkbox"/>	8-29-85	19		M
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
MALE		BLACK		8 10 21		64 yrs.						8-29-85	19		12:20	
7a. BIRTHPLACE - (STATE OR FOREIGN COUNTRY)		BALTO., MD.		7b. CITIZEN OF WHAT COUNTRY?		USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Baltimore City				
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Baltimore				4931 Herring Run Drive								RETIRED				MD.
13a. STATE MD.				13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4931 HERRING RUN DR.		21214				
14. FATHER'S NAME FIRST LOUIS				MIDDLE		LAST WILLIAMS		15. MOTHER'S MAIDEN NAME FIRST ANNABELL						LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 212-14-2847		17. INFORMANT CHARLOTTE WILLIAMS 7113 RUDISILL CT.		ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Blunt force injuries to head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY ? HOUR A.M. MIN. 8-29-85 YEAR P.M. 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2 subject assaulted										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION 4931 Herring Run Drive Baltimore, Maryland										
22. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.								DATE SIGNED 8-30-85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 9-2-85		23c. NAME OF CEMETERY OR CREMATORIAL GARRISON FOR. VET.		23d. LOCATION CITY OR TOWN OWINGS MILLS, MD.		COUNTY		STATE				
24. FUNERAL DIRECTOR LEROY O. DYETT ADDRESS 4600 LIBERTY HTGS AVE.				25a. DATE REC'D. BY REGISTRAR SEP 3 1985								25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pondell</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

220049 22173

ITEM NUMBER 13A PER PH. DEPARTMENT OF HEALTH AND MENTAL HYGIENE
STATE REGISTRAR CALL 8-21-85 D.W. CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			OTIS		WILLIAMS	8-1-85				140P.M.	
3. SEX		4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS EAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male		Black	Juner 20, 1918			67			MONTHS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
Darlington S.C.		U.S.A.				Baltimore, City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE CITY		PROVIDENT HOSPITAL BALTIMORE									
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Md.			Baltimore						426 HUTCHING AVE. 21212		
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Jeff Williams					Tiller Moses						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
					Willie Williams, 426 Hutchins Ave. 21212						
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary Arrest</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Embolism</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CAT cardiomyopathy</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN	21h. COUNTY	21i. STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7-23</u> 19 <u>85</u> to <u>8-1</u> 19 <u>85</u> , that (I) (we) lost sow the deceased alive on <u>8-1</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22c. DATE SIGNED
22b. SIGNATURE		22d. DEGREE			22e. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22f. ADDRESS			
Sher Afzal Hashmi MD								2600 LIBERTY HEIGHTS AVE 212157			8-1-85
22a. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. NAME OF CEMETERY OR CREMATORIAL			22d. LOCATION						
SHER AFZAL HASHMI		West View Mem Pk.			Baltimore, Maryland						
23a. BURIAL, CREMATION, REMOVAL		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			23e. DATE RECEIVED BY REGISTRAR		
Burial		8/5/85	West View Mem Pk.			Baltimore, Maryland			23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR		Law Funeral Home 4611 Park Heighta Ave. 21215						AUG 6 1985			JULIA SANDERS-KENDALL
(VRA 15, 4)											

226055

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. MEDICAL EXAMINER ALONE WITH FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 1A-3 SHOULD BE FILLED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 BALTIMORE, MARYLAND.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 2174								
1. FOR STATE REGISTRAR			LAST									2a. DATE KNOWN OF ESTI- DEATH MATED								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			IF UNDER 1 YR. MONTH DAYS HOURS MIN			XX MONTH DAY YEAR								
Rose			Lee			Williams						8-7 19 85								
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			2b. HOUR MONTH DAY YEAR								
Female			White			10 19 24			60			24 HOUR 1:12 a.m.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?									2c. DATE PRONOUNCED DEAD								
Maryland			U.S.A.									8-7 19 85								
9. BALTIMORE CITY OR COUNTY OF DEATH			Baltimore City,									MD.								
10. CITY OR TOWN OF DEATH			Church Home Hospital									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)								
Baltimore												Housework								
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12b. KIND OF BUSINESS OR INDUSTRY																	
13a. STATE Maryland			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2216 Essex Street 21231								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME SUSAN M. SULLIVAN																	
John William Arthur Hellman			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)																	
No			16b. SOCIAL SECURITY NO. 213-20-9055																	
17. INFORMANT			ADDRESS																	
Virgil L. Williams			2216 Essex St. 21231																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																				
{ (b) DUE TO, OR AS A CONSEQUENCE OF																				
(c)																				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																				
Diabetes Mellitus and Obesity																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?								
NO <input type="checkbox"/>												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>												TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 8-7-85		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8-9-85			23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION Garrison Forest, Balto., Md.											
24. FUNERAL DIRECTOR NAME			ADDRESS Charles S. Zeiler & Son Inc. 901 S. Conkling St.									25a. DATE REC'D. BY REGISTRAR AUG 9, 1985								
BP												25b. BUREAU OF VITAL RECORDS								
DHMH - 17 (VR A15 ME (5))																				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be sent to the funeral director, plate 3 should be attached for use in the burial container. Then please remove service papers. Papers 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22 / 75			
										REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		VERNISHA (Williams)		S.		(Vernisha)		8 28		85			12:05pm
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		Black		11 26 00		84		MONTHS		DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
N. Carolina		U.S.A.				Baltimore City		Baltimore		Pleasant Manor Nursing Center		12b KIND OF BUSINESS OR INDUSTRY	
13d. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		MD.			
Md.				Baltimore		YES <input checked="" type="checkbox"/>		2609 Cecil Ave. 21218					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST				
		Eddie		Strong			Martha						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		243-56-9039		Vernisha E. Harris		2609 Cecil Avenue				1 day			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b)		aliquenes disease						4 years			
		DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
None													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED <input type="checkbox"/> WHILE WORKING <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 22</u> , 19 <u>84</u> to <u>Aug 28</u> , 19 <u>85</u> , that (I) <u>saw the deceased alive on Aug 25, 1985</u> , and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.													
22b. SIGNATURE <u>Theresa Lewis</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/25/85</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MANUEL LEVIO M.D.</u>		22e. ADDRESS <u>6101 Pk Hts Ave BALTO MD 21215</u>											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 9/1/85		23c. NAME OF CEMETERY OR CREMATORIAL Ayden Cemetery		23d. LOCATION Ayden, NC							
24. FUNERAL DIRECTOR Wm C Marc h F/H Inc. 1101 E North Ave.				25a. DATE REC'D. BY REGISTRAR AUG 30 1985		25b. REGISTRAR'S SIGNATURE <u>Lidia Friedman-Pandale</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove from this page. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

(IMPORTANT) If item 21 is marked or item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 22176											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR
Williams, Viola						8 5 85					5:33 P.M.
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7d. HOUR	
FEMALE			BLACK		MONT DAY YEAR NOV 27 1906 78		IF UNDER 1 YEAR YRS. MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
N.C.			U.S.A.				Baltimore City			BALTO. City	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BALTO. City			MT. VERNON CARE CENTER		Retired					21207	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE	
Md.					BALTO.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			4200 Maine Ave.	
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST		
Unknown			un	K.	Martha Pratt			ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) 16b. SOCIAL SECURITY NO.											
16c. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cardiac arrhythmia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Berealized Appendicitis</u>											
16d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
17. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
18a. DATE OF OPERATION			18b. CONDITION FOR WHICH OPERATION WAS PERFORMED			28a. AUTOPSY?			28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
18b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY FROM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
21g. I certify that (i) this hospital examined the deceased from <u>8/2</u> to <u>8/5</u> , 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated. Now the deceased alive on <u>8/2</u> , 1985, and that in my (our) opinion death occurred on the date and hour and from the causes stated. (ii) we did not view the body after death.											
21h. SIGNATURE						DEGREE:			21i. DATE SIGNED		
21j. PHYSICIAN'S NAME (TYPE OR PRINT)			21k. ADDRESS						8/5/85		
Reuben Reider MD			7445A Furnace Branch Rd								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY/TOWN			23e. DATE REC'D. BY REGISTRAR	
Burial			8-9-85		Mt. Calvary Cem.		BALTO. MD			Aug 6 1985	
24. FUNERAL DIRECTOR NAME			ADDRESS		25b. REGISTRAR'S SIGNATURE						
Calvin B. Scruggs 14125 Preston St.					John L. Johnson, Esq.						
DHMH - 16 50M 4/83 (VRA 15, 4)											

ISSUES

30%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

REMOVED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it should be detached for use as the burial/transit permit. Then please remove carbons page 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 5 22177	
1. DECEASED NAME (TYPE OR PRINT)		FIRST HAZEL O.	MIDDLE WILLIS	LAST	2a. DATE OF DEATH MONTH DAY YEAR 8 25 85	2b. HOUR 1:20 PM
3. SEX FEMALE		4 RACE BLACK	S. DATE OF BIRTH MONTH DAY YEAR 05 25 04	6 AGE IN YEARS LAST BIRTHDAY 81	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10 CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MARYLAND		13b. COUNTY	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2938 ELLIOCOTT DRIVE 21216	
14. FATHER'S NAME FIRST GENERAL BOWIE		MIDDLE 	LAST 	15. MOTHER'S MAIDEN NAME FIRST MAGGIE	MIDDLE 	LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-74-1101		17. INFORMANT MARGARET SCOTT	ADDRESS 2938 ELLIOCOTT DRIVE	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		RESPIRATORY FAILURE				
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
		DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC FAILURE				
		DUE TO, OR AS A CONSEQUENCE OF (c) RENAL FAILURE				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/25/85 to 8/25/85 , that (I) (we) last saw the deceased alive on 8/25/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we), (and) (did) (did not) view the body after death.						
22b. SIGNATURE AMBACHEN Loreta M.		DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/28/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AMBACHEN Loreta M.		22e. ADDRESS 9233 WINDING WAY, ELLIOT CITY MD 21043				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/29/85	23c. NAME OF CEMETERY OR CREMATORIAL MT. ZION CEMETERY		23d. LOCATION CITY OR TOWN LUMBERTON NORTH CAROLINA	23e. COUNTY STATE MD 21043
24. FUNERAL DIRECTOR NAME WM. C. MARCH F/H 1101 E. North Avenue		ADDRESS	25a. DATE REC'D. BY REGISTRAR AUG 28 1985		25b. REGISTRAR'S SIGNATURE Leighland Pendell	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22178

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST ANNA	MIDDLE May	LAST WILSON	20. DATE OF DEATH MONTH 8	MONTH 3	DAY 85	YEAR 1985	2b HOUR 8:10 A.M.		
3. SEX FEMALE		4 RACE Black		5. DATE OF BIRTH MONTH 6			DAY 1	YEAR 06	6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 79		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.						
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4613 Park Heights Avenue 21215				
14. FATHER'S NAME FIRST Tom		MIDDLE		LAST Jackson			15. MOTHER'S MAIDEN NAME FIRST Hattie		MIDDLE		LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 214-20-6282		17. INFORMANT Alease Mae Reddicks			ADDRESS 3631 Park Hts. Ave						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF (b) MASSIVE PNEUMONIA													
(c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/30/85 , 19 85 , to 8/3/85 , 19 85 , that (I) (we) last saw the deceased alive on 8/3/1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Kirtikant Desai</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8/3/85			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) KIRTIKANT DESAI		22f. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 8/9/85		23c. NAME OF CEMETERY OR CREMATORIAL Arbutus Memorial Bk. Arbutus,			23d. LOCATION CITY OR TOWN Arbutus		COUNTY	STATE	Md.		
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.		ADDRESS 1101 E North Avenue		25a. DATE REC'D. BY REGISTRAR AUG 8 1985			25b. REGISTRAR'S SIGNATURE <i>John Davidson - Pendleton</i>						
DHMH - 16 60M 7/84 (VRA 15, 4)													



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
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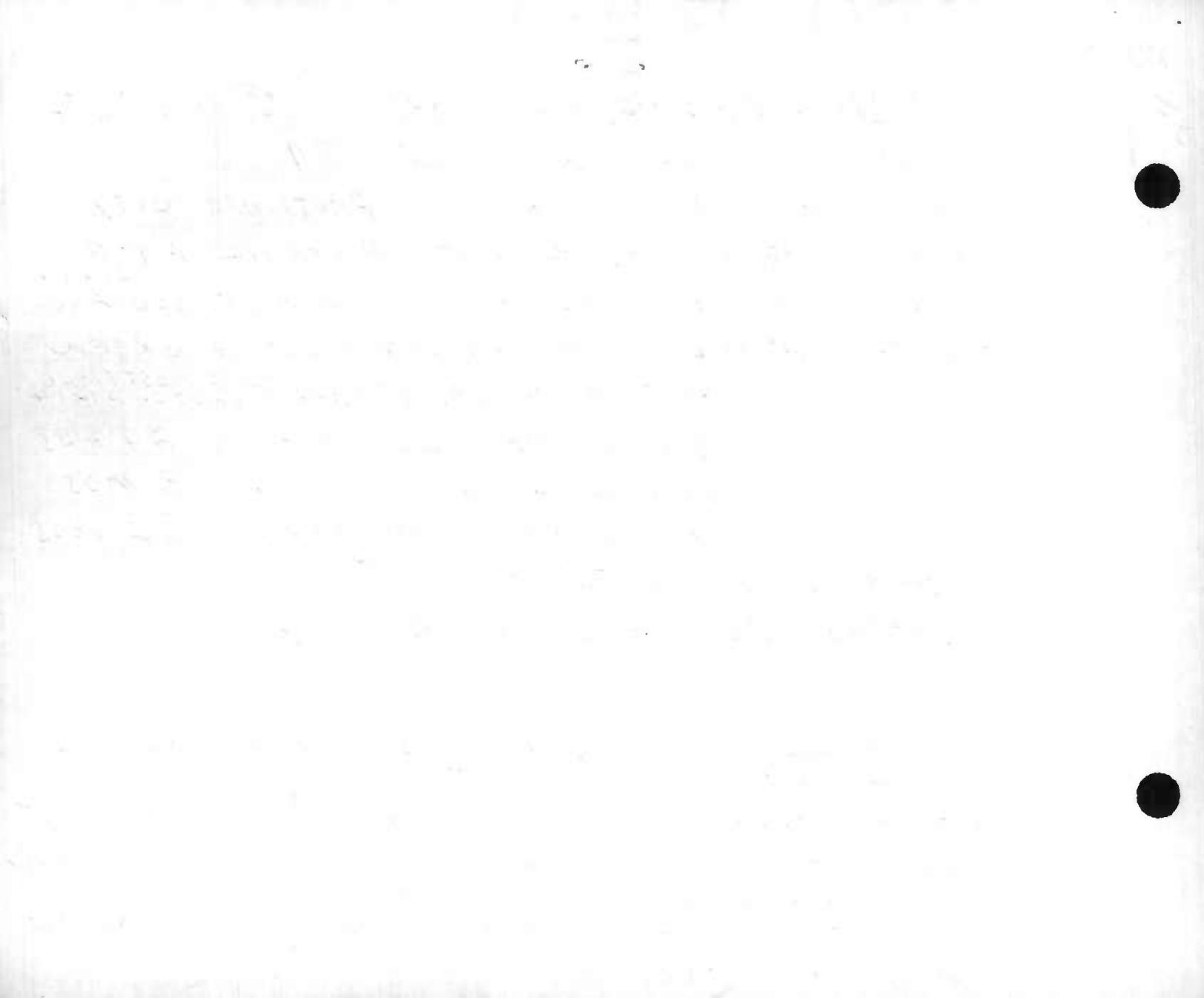
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH	MONTH	DAY	YEAR	2d. HOUR		
CHARLES HAYWOOD WILSON, SR.						8 13 85				6 ⁰⁴ p.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE		CAUCASIAN		MONTH	DAY	YEAR	80	YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
NORTH CAROLINA		U.S.				BALTIMORE CITY						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY		
BALTO. CITY		3203 WESTFIELD AVE.		MECHANIC						AUTO		
13. STATE		14. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21214		
Md.				BALTIMORE				3203 WESTFIELD AVE.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
RICHARD HAYWOOD WILSON					MARY NANCY OCTAWE GREEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
NO		216-10-8557 GLADYS STARR		3203 WESTFIELD BALTO. 21214								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED CANCER 3 mos Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
DUE TO, OR AS A CONSEQUENCE OF (c) PROSTATE CANCER 3½ mos												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) BRAIN METASTASIS												
19a. DATE OF OPERATION 5/17/85		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PROSTATE CANCER		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 7/31 1985		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) the physician attended the deceased from 6/1/1985 to 8/13/1985, and that in my opinion death occurred on the date and hour and from the causes stated saw the deceased alive on 7/31 1985 and that in my opinion death occurred on the date and hour and from the causes stated above, and (b) I did not view the body after death.												
22b. SIGNATURE Samuel J. Hassenbusch, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/13/85						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL J. HASSENBUSCH		22e. ADDRESS 1620 Roundhill Rd/BALTO. MD. 21218										
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 08/17/85		23c. NAME OF CEMETERY OR CREMATORIUM PARKWOOD		23d. LOCATION CITY OR TOWN BALTIMORE COUNTY BALTO. MD.		23e. DATE REC'D. BY REGISTRAR AUG 16 1985				
24. FUNERAL DIRECTOR NAME John J. Hassenbusch		ADDRESS 1211 Chesapeake Ave.		25e. REGISTRAR'S SIGNATURE John Davidson-Randall								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			EVA	M.	WILSON	AUGUST 15, 1985			11:40A M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		Black		MONTH	DAY	YEAR	72	IF UNDER 24 HRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Georgia		U.S.A.					BALTIMORE CITY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		THE JOHNS HOPKINS HOSPITAL										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
Maryland				Baltimore				3603 Gwynn Oak Avenue 21207				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
Richard				Pollox	Leola				Cole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
NO		219-16-5362		Etta Cozart 3603 Gwynn Oak Avenue								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>asystolic arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Probable septic/spontaneous bacterial peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>end stage cirrhotic liver disease</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> , 19 <u>85</u> , to <u>8-15</u> , 19 <u>85</u> , that (I) <u>we last</u> saw the deceased alive on <u>8-15</u> , 19 <u>85</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We did (did not) view the body after death.)												
22b. SIGNATURE <u>H. Steiner</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input checked="" type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8-15-85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>STEINER</u>		22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u>		23b. DATE <u>8/20/85</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Baltimore Cemetery</u>		23d. LOCATION CITY OR TOWN <u>Baltimore</u> , COUNTY <u>Md.</u> STATE						
24. FUNERAL DIRECTOR NAME <u>Wm C March F/H Inc.</u>		ADDRESS <u>1101 E North Avenue</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 20 1985</u>		25b. REGISTRATION SIGNATURE <u>Jeanne Davidson-Purcell</u>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22781

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (MOM RUBY) (BABY BOY)				FIRST James	MIDDLE Marshall	LAST Wilson	2a. DATE OF DEATH 8/29/85	MONTH	DAY	YEAR	2b. HOUR 7:55 AM								
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 8			DAY 16	YEAR 85	6. AGE (IN YEARS LAST BIRTHDAY) MONTHS 13										
7a. BIRTHPLACE MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			10. CITY OR TOWN OF DEATH BALTIMORE CITY									
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FRANCIS SCOTT KEY Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) INFANT			12b. KIND OF BUSINESS OR INDUSTRY MD. 21217			13a. STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore						
14. FATHER'S NAME FIRST THEODORE L		MIDDLE HUNTER	LAST	15. MOTHER'S MAIDEN NAME FIRST Ruby			MIDDLE Wilson	LAST WILSON	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Ruby Wilson MOTHER			ADDRESS 1708 N. Calhoun Street 21217 BALTIMORE, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC FAILURE												2 days							
DUE TO, OR AS A CONSEQUENCE OF (c) TOTAL RENAL FAILURE												5 days							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a RESPIRATORY COMPRAMISE, HEPATITIC DAMAGE, UNCERTAIN ETIOLOGY																			
19a. DATE OF OPERATION 9/9		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from 8/16 1985 to 8/29 1985 , that (I) (we) last saw the deceased alive on 7:55 AM 8/29 1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE Mark D Harris		22c. DEGREE			22d. DATE SIGNED 8/29/85														
22e. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22f. ADDRESS 513 NUTTINGHAM RD BALTO., MD 21229																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/4/85		23c. NAME OF CEMETERY OR CREMATORIAL Mount Calvary Cem.			23d. LOCATION CITY OR TOWN Anne Arundel Co., Md												
24. FUNERAL DIRECTOR NAME Wm C March F/H Inc.												25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE Susan Gordon					
DHMH - 16 50M 1/B1 (VRA 15, 4)																			

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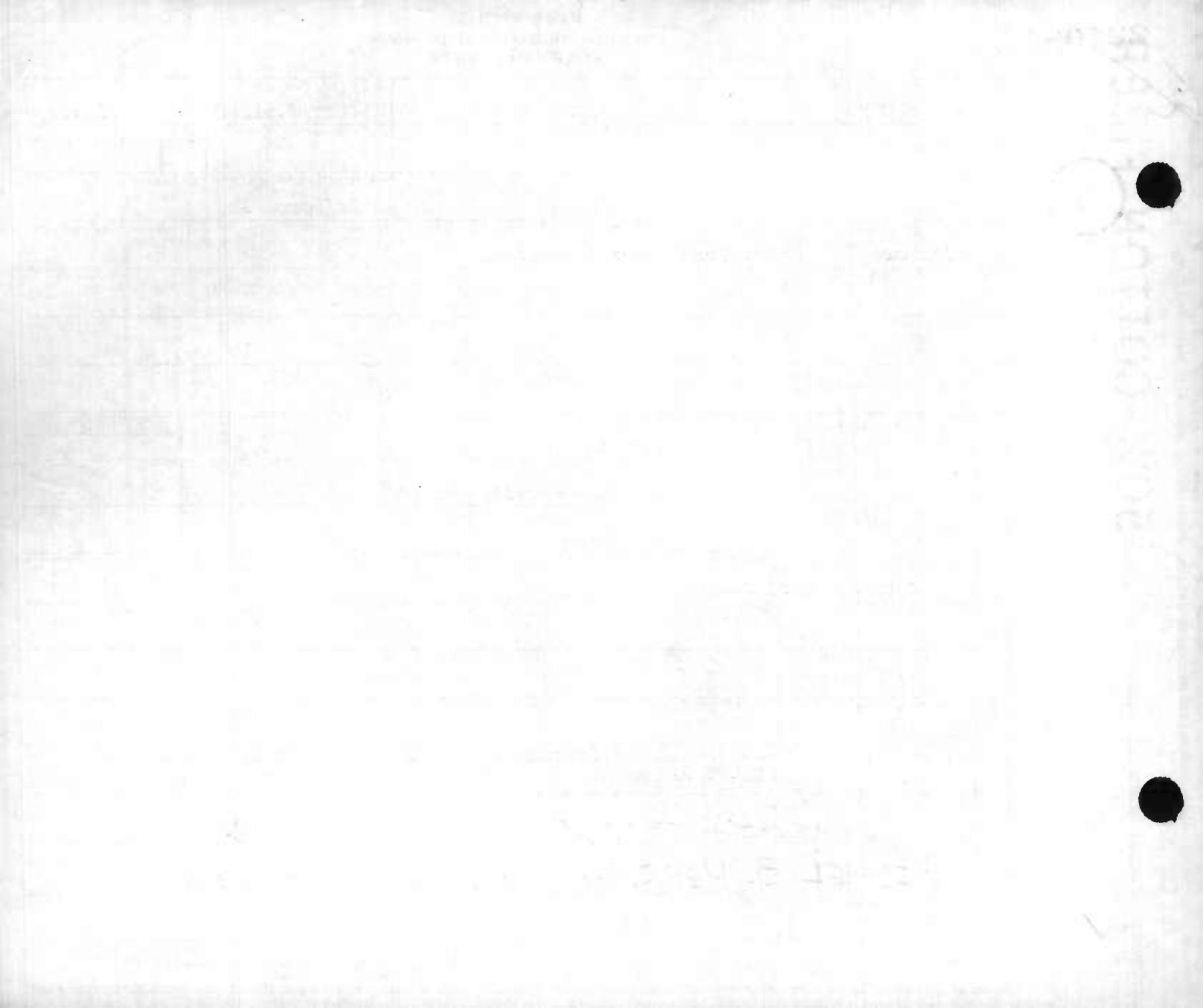
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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon copy. Pages 3 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 22182	
1. DECEASED NAME (TYPE OR PRINT) PATSY			MIDDLE WILSON	LAST	2a. DATE OF DEATH AUGUST 5, 1985	MONTH DAY YEAR 10 15 85	2b. HOUR 10:28 PM
3. SEX Female	RACE Black	S. DATE OF BIRTH MONTH DAY YEAR 10 15 34	6. AGE (IN YEARS LAST BIRTHDAY) 50	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE COUNTRY N.C.	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
13a. STATE MD	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 5109 Herring Run Dr. 21214			
14. FATHER'S NAME FIRST Ernest	MIDDLE Moore	LAST	15. MOTHER'S MAIDEN NAME FIRST Nonie	MIDDLE	LAST Rawls		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No	16c. SOCIAL SECURITY NO. 245-56-8267	17. INFORMANT Joseph B. Wilson	ADDRESS 5109 Herring Run Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY Arrhythmia IMMEDIATE CAUSE (a)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Status Post Cardiac Arrest							
DUE TO, OR AS A CONSEQUENCE OF (c) Hyperkalemia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Chronic Renal Failure							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 5, 1985 to August 5, 1985 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on August 5, 1985 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Michael B. Herry, M.D.</i>	DEGREE <i>M.D.</i>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED August 8, 1985		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL B. HERRY, M.D.	22e. ADDRESS c/o Maryland General Hospital						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8/9/85	23c. NAME OF CEMETERY OR CREMATORIUM Garrison Forest VA	23d. LOCATION CITY OR TOWN Owings Mills	COUNTY	STATE	MD	
24. FUNERAL DIRECTOR Wm. C. March F/H	25a. DATE REC'D. BY REGISTRAR AUG 8 1985	25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Hendell</i>					

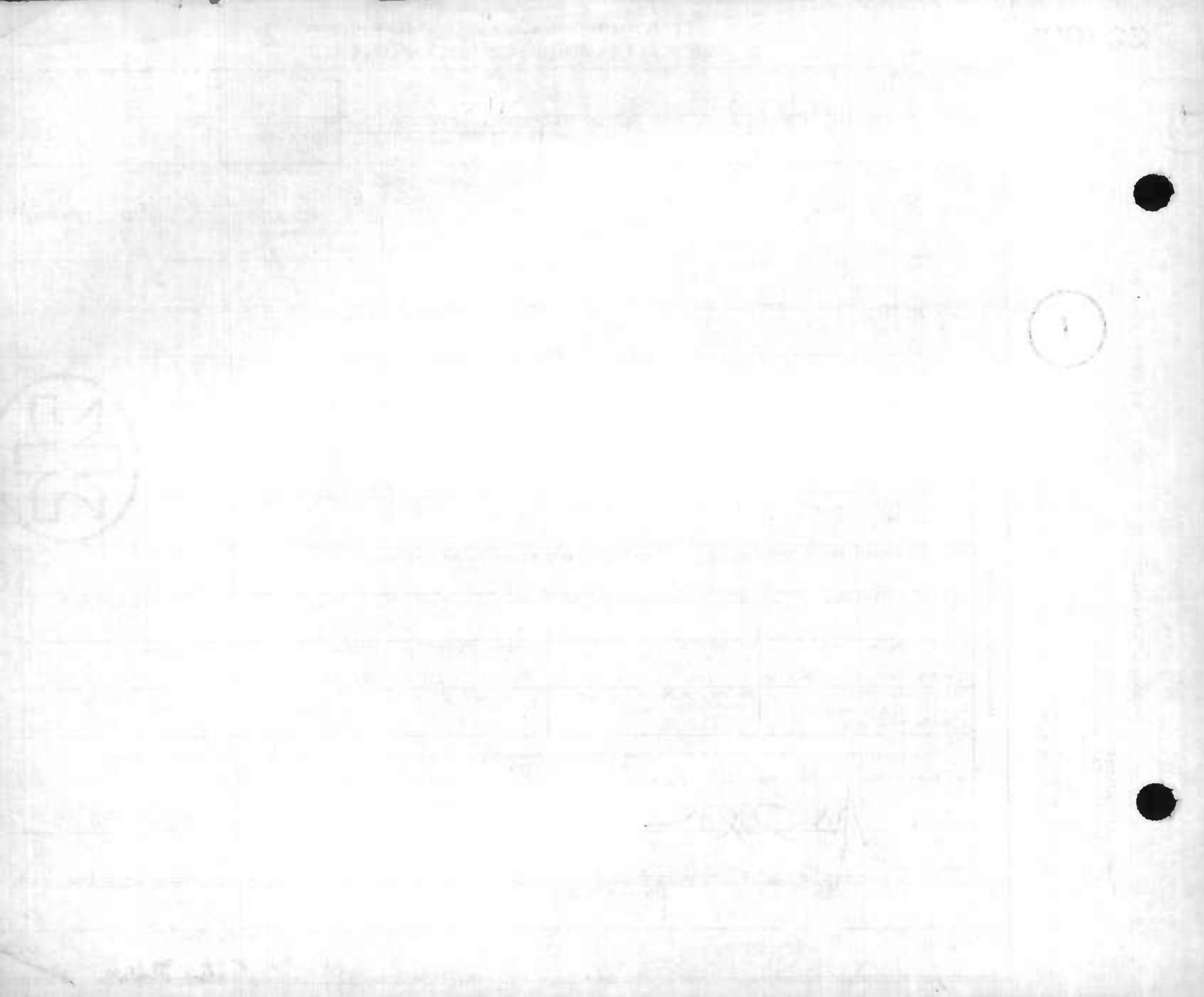


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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, WITH FORM NO. 3 RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM NO. 3. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 22183					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED	<input checked="" type="checkbox"/>	MONTH	DAY	YEAR	2b. HOUR
Samuel ADOLPHUS Wilson												8	5	1985	M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR	
MALE		BLACK		11 18 22		62 yrs.						8 5 1985				9:50 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			X NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND			U.S.A.									Baltimore City,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Baltimore			Sinai Hospital			RET. U.S.A. ARMY			ARMY			21218					
13a. STATE MARYLAND			13b. COUNTY			13c. CITY OR TOWN BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 4413 MARBLE HALL ROAD					
14. FATHER'S NAME FIRST SAMUEL			MIDDLE A.			LAST WILSON			15. MOTHER'S MAIDEN NAME DELTA			LAST HARRIS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. KOREAN			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8120 IMMEDIATE CAUSE (a) Multiple injuries Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR XX MONTH DAY YEAR 6:50 P.M. 8 5 1985			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) Driver in auto/auto impact											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street			21f. LOCATION STREET CITY OR TOWN LIBERTY HGTS & NORTHERN PKWY, BALTO CITY, MD.			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 8/6/85					
EXAMINER'S NAME (TYPE OR PRINT)			Ann M. Dixon, M.D.			ADDRESS 111 Penn St. Balto. MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8-12-1985			23c. NAME OF CEMETERY OR CREMATORIAL GARRISON FOREST			23d. LOCATION CITY OR TOWN BALTIMORE COUNTY			COUNTY			STATE		
24. FUNERAL DIRECTOR NMUTTER & SONS FUNERAL HOME, INC. BA 2501 GWYNNS FALLS PKWY.						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								



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1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22184

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH D. WILZEN				2a. DATE OF DEATH MAY JUNE 7 1985	MONTH JUN	YEAR 85	2b. HOUR 10
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MAY 6 1910	6. AGE (IN YEARS LAST BIRTHDAY) 75				
7a. BIRTHPLACE COUNTRY MASS.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1213 GLENEAGLE ROAD 21239	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE				
13a. STATE MARYLAND		13b. COUNTY 21239	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MARTIN		MIDDLE 	LAST FEENEY	15. MOTHER'S MAIDEN NAME FIRST BERTHA	MIDDLE M.	LAST MOONEY	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. -----014-16-1115		17. INFORMANT JOEL D. FEDDER	ADDRESS BALTO., MD 21202		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anemic myocardial infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 AM			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>PSCLVD -</i>				10 yr -			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any } (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Recurrent (Racoon 2 yrs)			19a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) 5/6/85				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET 6610 CROSS COUNTRY BLVD	CITY OR TOWN Baltimore City, Md.	COUNTY 	STATE 	
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8/1/85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. Maurice Feldman</i>		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/20/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR MAURICE FELDMAN		22e. ADDRESS 6610 CROSS COUNTRY BLVD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/21/85	23c. NAME OF CEMETERY OR CREMATORIAL Green Mount Crematory	23d. LOCATION CITY OR TOWN Baltimore City, Md.	23e. COUNTY 	23f. STATE 	
24. FUNERAL DIRECTOR William E. Johnson		ADDRESS 8521 Loch Raven Blv.	25a. DATE REC'D. BY REGISTRAR AUG 21 1985		25b. REGISTRAR'S SIGNATURE <i>John E. Johnson</i>		

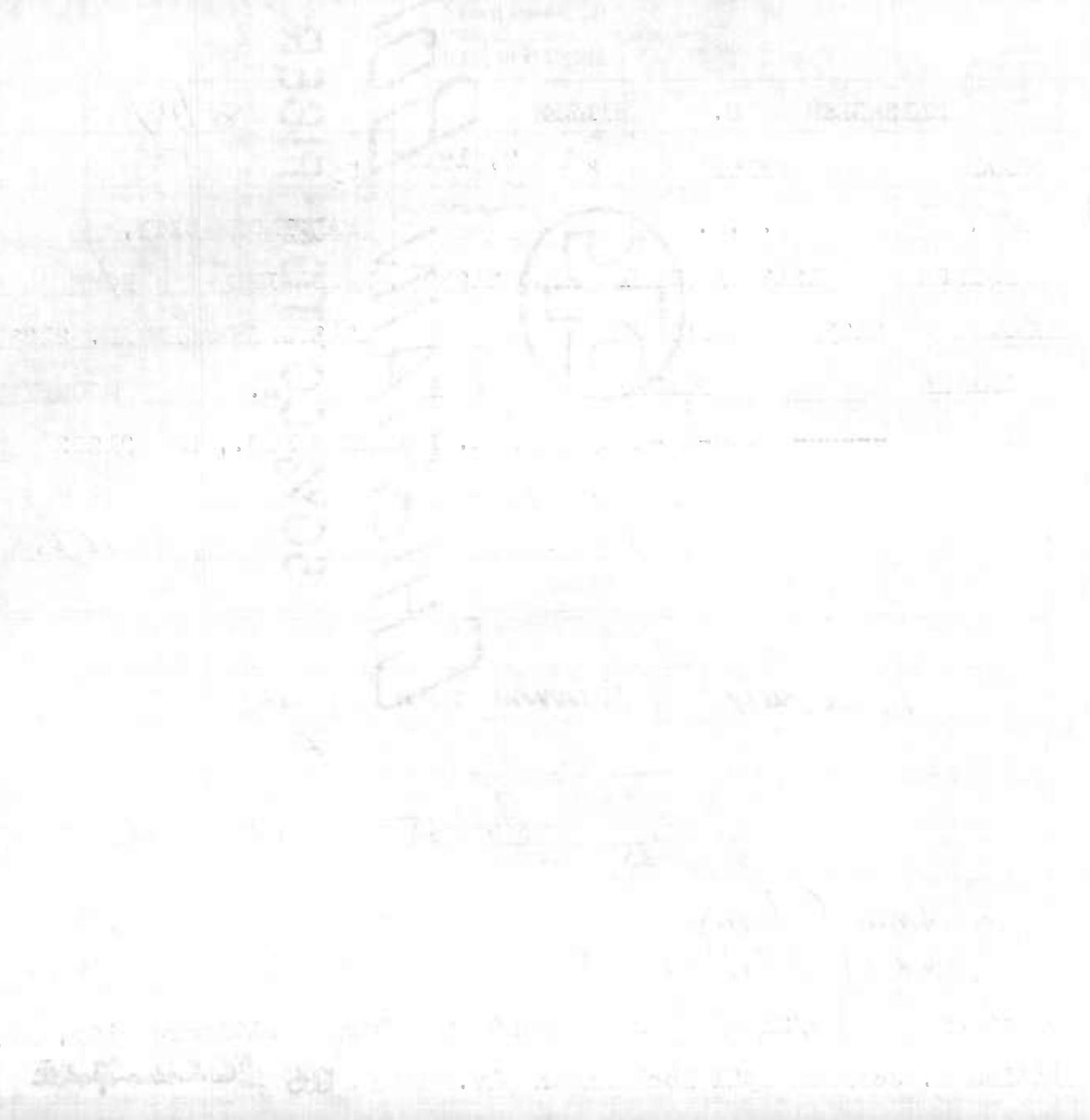
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 2 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon patient. Page 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22783	
										REG. NO.	
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)				FIRST DOROTHY	MIDDLE R.	LAST WINEBRENNER		2b. DATE OF DEATH AUGUST 7, 1985	MONTH DAY YEAR
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH 10 -DAY 3 -YEAR 1924		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERICAL		12b. KIND OF BUSINESS OR INDUSTRY CITY					
13a. STATE MD.		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 3312 TEXAS AVE. 21234			
14. FATHER'S NAME FIRST JOHN RUDICKA		LAST		15. MOTHER'S MAIDEN NAME FIRST ANNA KOVANDA						LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-20-0123		17. INFORMANT Mr. Charles E. Winebrenner Jr.		ADDRESS 3312 TEXAS AVE. 21234		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 minutes			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiovascular arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic breast CA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (# EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/7/85 , 19 85 , to 8/7 , 19 85 , that (I) (we) last saw the deceased alive on 8/7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Steven I. Sherman</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 9/7/85					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven I. Sherman		22e. ADDRESS Johns Hopkins Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-10-85		23c. NAME OF CEMETERY OR CREMATORIAL PARKWOOD Cem.		23d. LOCATION CITY OR TOWN BALTO. MD.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME <i>Barbara Miller - 7527 Bradford Rd.</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 9 1985		25b. REGISTRAR'S SIGNATURE <i>Julie Carlson-Pondell</i>					
DHMH - 16 50M 4/B3 (VRA 15, 4)											



253030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copy pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22 / 80				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
DORA			M.	WINKLER		8			20	85	P 11:00 M					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		MONTH	DAY	YEAR	94			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland		U.S.					Balto. City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Balto.		3102 Keswick Rd.		Homemaker												
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			21211						
Md.			Balto.				3102 Keswick Rd.									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
		Bernard	M.	Honemann	Sophie					Berry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS									
No		219-58-0287		Mr. Francis E. Winkler - Same as #13												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Valvular Heart Disease</i>												<i>year</i>				
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>1981</i> , 19, to <i>21/20</i> , 19, <i>85</i> , that (I) (we) last saw the deceased alive on <i>8/18/85</i> , 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE <i>Richard L. Diemer</i>												DEGREE				
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Richard L. Diemer</i>												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN									
Removal		8/21/85														
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Anatomy Board		Balto., Md.			AUG 29 1985			<i>Julia Davidson-Randall</i>								

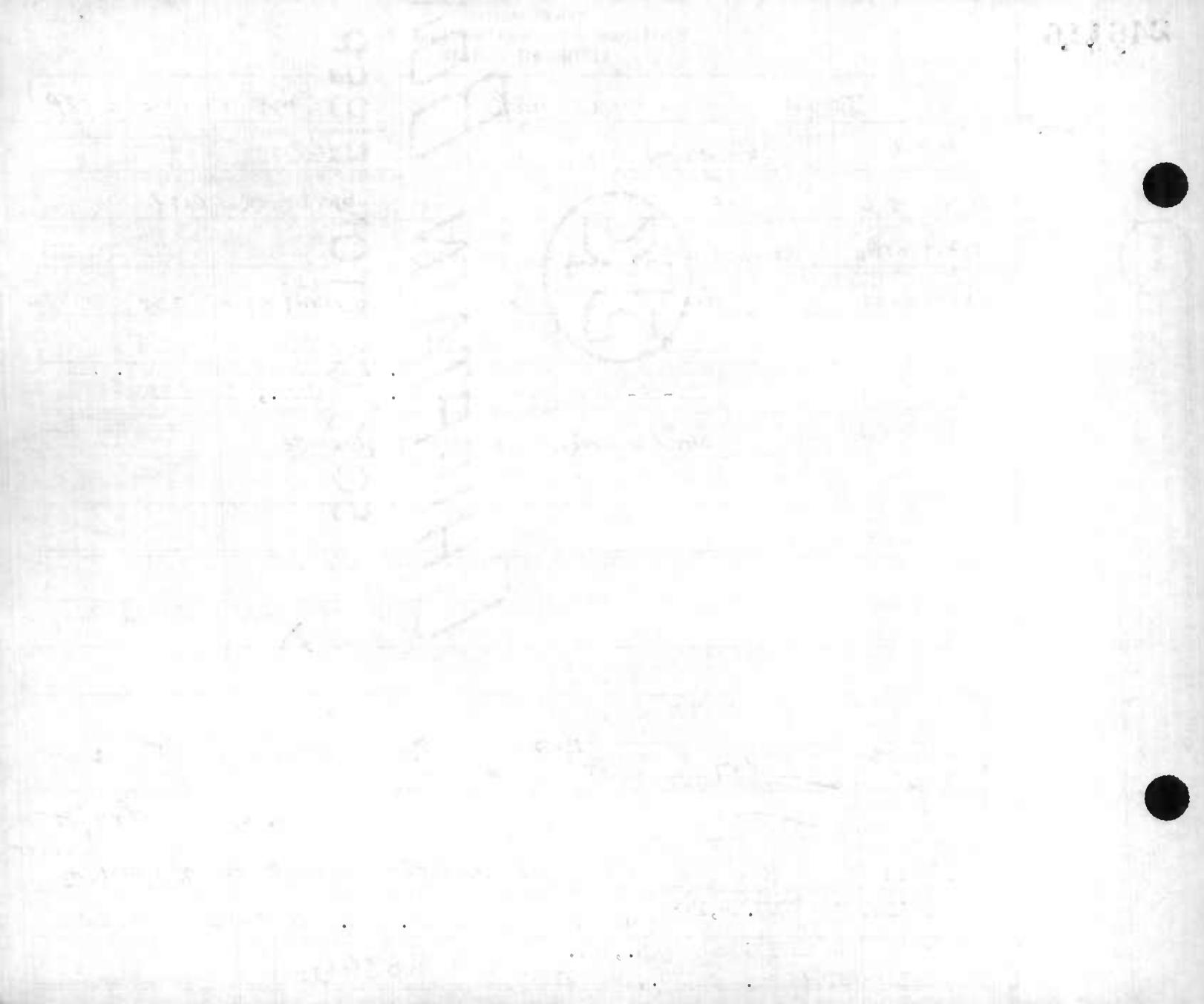
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22 / 8 / 1	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
JACOB					WINNER	Aug. 27, 1985					1985	3:08 P.M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR	
MALE			CAUCASIAN			MONTH DAY YEAR			XXX 75 YRS			MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
WASH. D.C.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE			LEVINGRAVE HEBREW GERIATRIC CENTER & HOSPITAL			ENGINEER			ELECTRONICS				
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
MARYLAND									600 LIGHT ST. APT. 725 21230				
14. FATHER'S NAME FIRST			MIDDLE	LAST		15. MOTHER'S MAIDEN NAME			ADDRESS				
SAMUEL				WINNER		FANNIE			VICTORIA MAZOR				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			APT. 725				
NO			215-32-8192			MRS. THERESA WINNER			600 LIGHT ST. BALTO., MD 21230				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE CONGESTIVE HEART FAILURE												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (this hospital) attended the deceased from 8/27, 1985, to 8/27, 1985, that (we) last saw the deceased alive on 8/27, 1985, and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED				
ESTRELITA O. KW			M.D.			LEVINGRAVE HEBREW GERIATRIC CENTER & HOSPITAL			8/27/85				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL HEBREW ORTHODOX MEM.			23d. LOCATION CITY OR TOWN			23e. MARYLAND	
BURIAL			AUG. 29, 1985			SOC. BALTIMORE			COUNTY			MARYLAND	
24. FUNERAL DIRECTOR NAME			SOL LEVINSON & BROS., INC.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
						AUG 30 1985							
6010 REISTERSTOWN RD., BALTO., MD 21215													



TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certification may be filed at the time of death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												5	22	88	
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Walter L. Witkofsky, Sr.			Walter	L.	Witkofsky	Aug. 2, 1985						1:05 A.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)			
Male			Cauc.			1/21/06						79	YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Balto., Md.			USA									Baltimore City			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Balto.			Mercy Hospital						Postal Clerk			USPostOffice			
13a. STATE Md.			13b. COUNTY <i>C</i>			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3221 Lawnview Ave. 21213			
14. FATHER'S NAME FIRST Joseph Witkofsky			MIDDLE			15. MOTHER'S MAIDEN NAME LAST Eva Sporney									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-32-6185			17. INFORMANT Verna Witkofsky, same address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 1 day			
DO TO, OR AS A CONSEQUENCE OF (b) Pulmonary Embolus												22 hrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c) Renal Failure												> 7 mos.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8/2/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									
Joan M. T. Collison M.D.			301 St. Paul Place, Balto., MD 21202												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8/5/85			23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus			23d. LOCATION Balto., Md.						
24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.			ADDRESS 3331 Brehms Lane, Balto., Md. 21213			25a. DATE REC'D. BY REGISTRAR AUG 6 1985			25b. REGISTRAR'S SIGNATURE Julia Davidson Pendell						
DHHM - 16 60M 7/B4 (VRA 15, 4)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please remove carbon papers. with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
William J. Witles							Witles		8 19 85			212 AM	
3. SEX <u>Male</u>			4. RACE <u>White</u>			5. DATE OF BIRTH MONTH DAY YEAR <u>1 25 1905</u>			6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u>			7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u>			MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Fairview Scott Key Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Retired</u>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Baltimore</u>			13c. CITY OR TOWN <u>Baltimore</u>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE <u>7120 River Dr. Rd., 21217</u>	
14. FATHER'S NAME FIRST <u>John Joseph</u>			MIDDLE <u>Witles</u>			LAST <u>Witles</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Antonia</u>			LAST <u>KIOSEREK</u>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Unknown</u>			16b. SOCIAL SECURITY NO. <u>216 01 4700</u>			17. INFORMANT ADDRESS <u>Louise Witles 7120 Ring Dr. #6 Sparrows Point, MD 21217</u>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEPTIC SHOCK</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>PNEUMONIA</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>				
20. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NOT WHILE AT WORK</u>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>saw the deceased alive on 8/19/85</u>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <u>Dept. Medicine, Johns Hopkins Hospital</u>			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4 AM 8/18</u> , 19 <u>85</u> , to <u>8/19</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/19/85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>Eric Brown</u>			DEGREE <u>MD</u>			22c. DATE SIGNED <u>8/19/85</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Eric Brown MD</u>			22e. ADDRESS <u>Dept. Medicine, Johns Hopkins Hospital</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>8/22/1985</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Oak Lawn Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Baltimore</u>			COUNTY STATE <u>Maryland</u>	
24. FUNERAL DIRECTOR Duda-Ruck, Inc. NAME <u>Duda-Ruck, Inc.</u>			ADDRESS <u>7922 Wise Avenue Dundalk, Maryland 21222</u>			25a. DATE REC'D. BY REGISTRAR <u>AUG 21 1985</u>			25b. REGISTRAR'S SIGNATURE <u>Jane Duda-Ruck</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be presented within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. There should remain carbon copies of pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

REPORTANT: If name 21 is marked in Item 18 shows any injury, an other traumatic event, the medical certifying physician must be notified at once.

238038

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22 / 90

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST DANIEL	MIDDLE JOHN	LAST WITT	2a. DATE OF DEATH MONTH 08/19/85	DAY YEAR	2b. HOUR 3:10 PM			
3. SEX Male			4 RACE White	5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 17			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		
10. CITY OR TOWN OF DEATH BALTIMORE CITY			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Sheet Metal Mech.			12b. KIND OF BUSINESS OR INDUSTRY Balto., Md.		
13a. STATE Md.			13b. COUNTY			13c. CITY OR TOWN Balto.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST Frank			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Wittkofsky MIDDLE Mary LAST Novak						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-0280			17. INFORMANT Mrs. Dorothy A. Witt			ADDRESS 304 S. Augusta Ave. - Balto., Md. #21229		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			MYOCARDIAL INFARCTION, ACUTE								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 85 to Aug 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE Michael E. Pagan			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8/20/85		
22e. ADDRESS ST. AGNES HOSPITAL											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment			23b. DATE Aug. 22/85			24. NAME OF CEMETERY OR CREMATORIAL Holy Redeemer Cemetery			25a. LOCATION ON OR IN COUNTY Balto.		
24. FUNERAL DIRECTOR G. Truman Schwab			25b. DATE REC'D. BY REGISTRAR AUG 22 1985			25b. REGISTRAR'S SIGNATURE Randall					

60045

of mail, and to such violations, and to
protect it from being used by persons

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and returned to you, it may be detached for use as the burial-tombstone permit. Then please remove carbon paper from the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							2219				
							REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
ANNA		C.		WOELFER	8 28 85		8 28 85			3:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		MONTH 5	DAY 17	YEAR 22	63		MONTHS YRS	DAYS	HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
MD.		U.S.A.				BALTIMORE CITY					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		SOUTH BALTIMORE GENERAL HOSP.		Clerk Typist		Balto., City					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		577 47TH Street, 21224	
MD.		BALTIMORE									
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	FOOKS			
CHARLES			CHRIST	CHRISTINE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		213183-950		Harry F. Woelfer		Same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest.</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Cholangio carcinoma of gastric ca.</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/28/85 to 8/28/85, that (I) (we) last saw the deceased alive on 8/28/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <u>B. Bassim Badro</u>		DEGREE MD.		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 8/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BASSIM BADRO		22e. ADDRESS SOUTH BALTIMORE GENERAL HOSP.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/1985		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		23d. LOCATION Glen Burnie		CITY OR TOWN		COUNTY	
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. 7922 Wise Avenue		ADDRESS Dundalk, Maryland 21222		25a. DATE REC'D. BY REGISTRAR SEP 3 1985		25b. REGISTRAR'S SIGNATURE June L. Johnson-Nichols					

EXCERPTS



248074

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22 / 92

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Leo L. Wojcik						8 27 85				7:00 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS HOURS MIN.		
Male	White	MONTH	DAY	YEAR	64						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Balto City			
PA.		USA									
10. CITY OR TOWN OF DEATH Balto City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ Hospital			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Beth Steel Worker			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13c. CITY OR TOWN Balto			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1722 Burnham Rd 2022			
14. FATHER'S NAME Michael		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Frances Selega							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes		16b. SOCIAL SECURITY NO WW II 207-07-0925			17. INFORMANT Charleen F. Wojcik			Same as 13e			
18. CAUSE OF DEATH (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b) AND (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Multi organ Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>All</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min 2 days 2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/27 1985 to 8/27 1985, that (I) (we) last saw the deceased alive on 8/27 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>K Snyder</u>		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8/27/85			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>K Snyder MD</u>		22f. ADDRESS Univ Hospt						22g. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/30/1985			23c. NAME OF CEMETERY OR CREMATORIAL Holly Hill			23d. LOCATION CITY OR TOWN White Marsh		COUNTY	STATE Maryland
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue		25a. DATE REC'D. BY REGISTRAR SEP 3 1985			25b. REGISTRAR'S SIGNATURE Gina Landon-Morrell						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be retained for use as the burial/transit permit. Then please remove carbon copy of this page, and 2a, should be buried within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, it must be reported to the medical examiner.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 21 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM W-3 RETAIN COPIES FOR YOUR FILES.

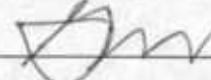
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 19 AND 20 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

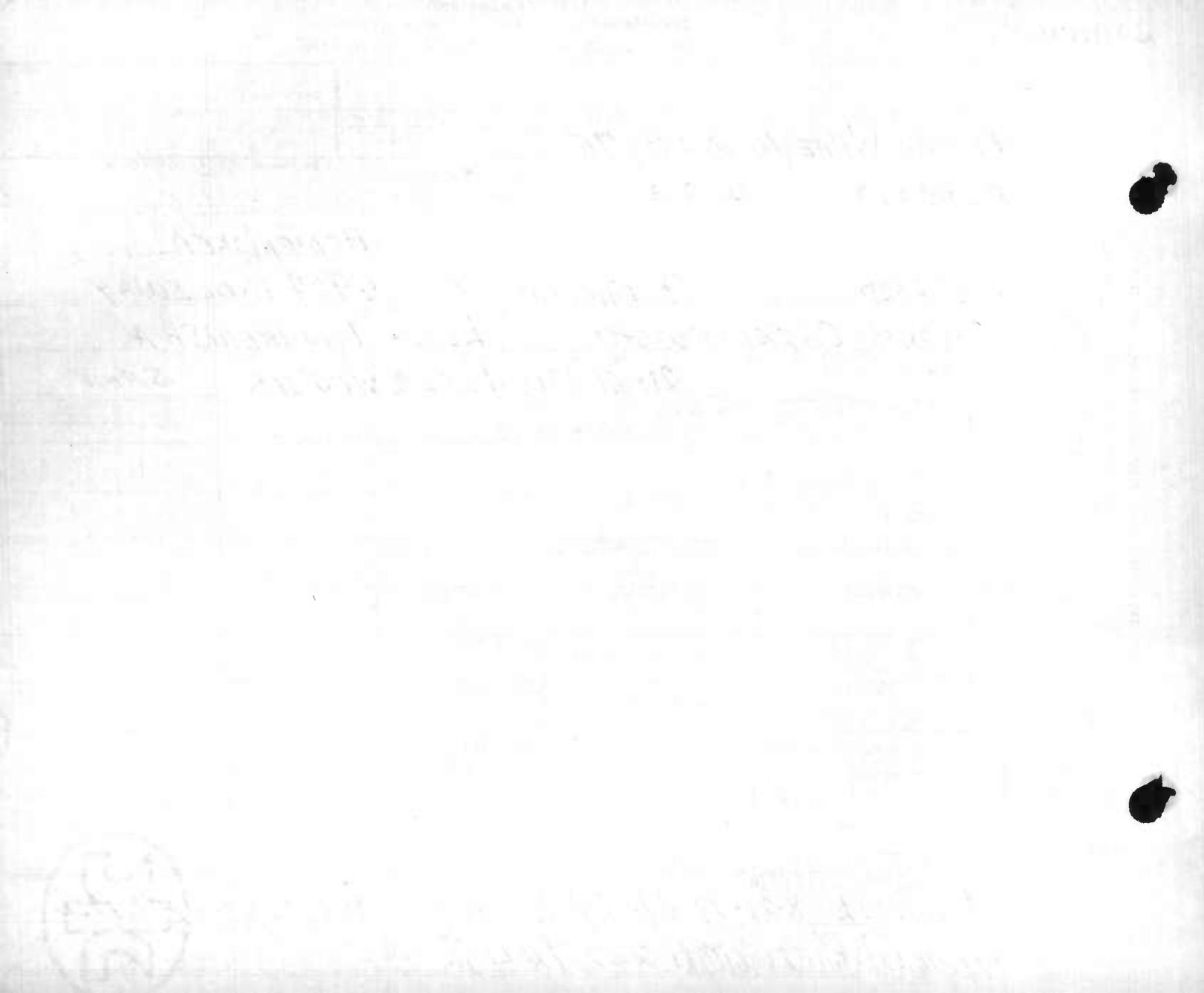
MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22193

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED	MONTH	DAY	YEAR	2b. HOUR		
Victoria					Wojcik	<input checked="" type="checkbox"/>				8/ 19/ 85		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
FEMALE	WHITE	10 10 1909	75			<input checked="" type="checkbox"/>				12:00		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U. S. A.				Baltimore City, MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		Francis Scott Key Medical Center			HOMEMAKER			21206				
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		14. FATHER'S NAME FRANK OSZAKIEWSKI		15. MOTHER'S MAIDEN NAME LENA FRANKOWSKA		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218 01 0316	17. INFORMANT PETER WOJCIK SAME
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE  TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER												
EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. ADDRESS 111 Penn St.												
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE 8-21-1985		23c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary		23d. LOCATION CITY OR TOWN BALTIMORE		23e. COUNTY MD.				
24. FUNERAL DIRECTOR NAME PAYMOND J. KACZOROWSKI		ADDRESS 2525 Fleet St.		25a. DATE REC'D. BY REGISTRAR AUG 23 1985		25b. REGISTRAR'S SIGNATURE 						
DHMH - 17 (VR A15 ME (5)) 20M 4/B2												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon dioxide (page 3) and attach to burial or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon dioxide (page 3) and attach to burial or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

RECEIVED
235111
6
BP

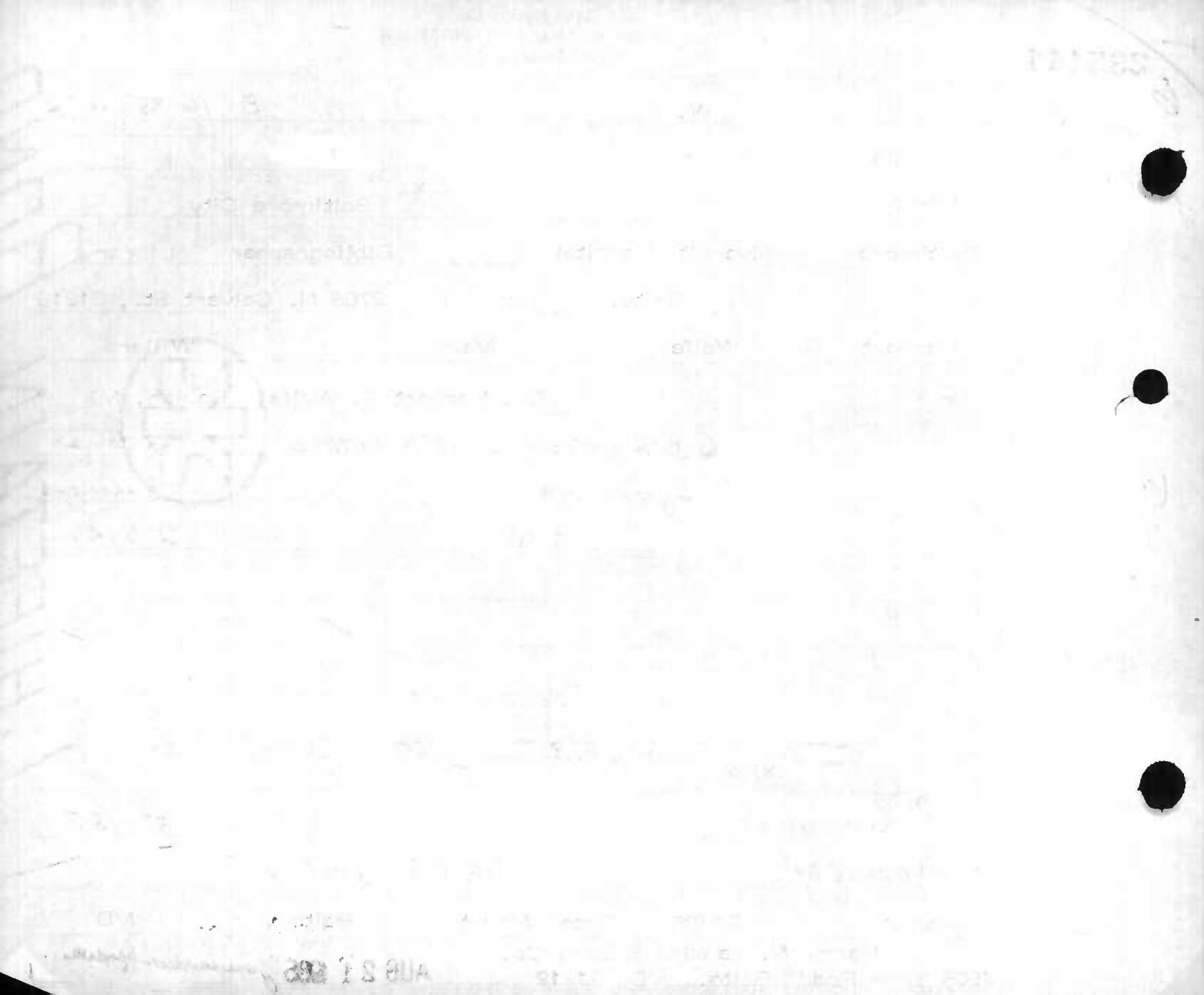
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

- 22194

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME WILLIAM W. WOLFE			2a. DATE OF DEATH 8 16 85	MONTH YEAR	DAY	2b. HOUR 1115 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 29, 1936	6. AGE (IN YEARS LAST BIRTHDAY) 49	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE Michigan	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION University Hospital	12a. USUAL OCCUPATION Bibliographer			12b. KIND OF BUSINESS OR INDUSTRY Library	
13a. STATE MD	13b. COUNTY BALTIMORE	13c. CITY OR TOWN Balto.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2708 N. Calvert St., 21218		
14. FATHER'S NAME Herbert S. Wolfe	15. MOTHER'S MAIDEN NAME Mary Willard					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN) No	16b. SOCIAL SECURITY NO. 	17. INFORMANT Dr. Herbert S. Wolfe, Beulah, MI	ADDRESS			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GASTROINTESTINAL HEMORRHAGE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
DUE TO, OR AS A CONSEQUENCE OF (b) HYPNOTIC						3 MONTHS
DUE TO, OR AS A CONSEQUENCE OF (c) AIDS						2-3 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) this hospital attended the deceased from 6/8 , 19 85 , to 8/16 , 19 85 , that (II) we last saw the deceased alive on 8/16 , 19 85 , and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) (II) (we) did not view the body after death.						
22b. SIGNATURE P. Kennedy DEGREE						
22c. ADDRESS UMMS YMCC			22d. DATE SIGNED 8/16/85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 8/20/85	23c. NAME OF CEMETERY OR CREMATORIAL Green Mount	23d. LOCATION CITY OR TOWN Balto.	COUNTY	STATE MD	
24. FUNERAL DIRECTOR NAME Henry W. Jenkins & Sons Co.	ADDRESS 4905 York Road Balto., MD 21212	25a. DATE REC'D. BY REGISTRAR AUG 21 1985	25b. REGISTRAR'S SIGNATURE Jane Davidson Pendell			



225004

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM RM 3 RETAIN - PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES RM 2 & RM 3 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DIVISION OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 22795

1 DECEASED NAME (TYPE OR PRINT)		FIRST Nathan	MIDDLE	LAST Wolkenberg	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 8 OF ESTI- DEATH MATED <input type="checkbox"/> DAY 219 HOUR 85 M		
3 SEX MALE	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 12-26-1905	6 AGE (IN YEARS LAST BIRTHDAY) 79 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8 219 85	2d HOUR 4:34P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) England		7b. CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City,		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) pipe fitter		12b. KIND OF BUSINESS OR INDUSTRY Navy Yard
13a. STATE Maryland		13b. COUNTY Talbot	13c. CITY OR TOWN Cordova	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D. #1, Box 208D/ 21625		
14. FATHER'S NAME FIRST Saul		MIDDLE Wolkenberg	LAST	15. MOTHER'S MAIDEN NAME FIRST Marion MIDDLE (unk)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR RECORDS) W.W. II		16c. INFORMANT Gloria A. Hawks	ADDRESS Easton, Md.		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1 DEATH WAS CAUSED BY: 8/20</p> <p>IMMEDIATE CAUSE (a) Multiple injuries DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</p> <p>(b) DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>							
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).</p>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XXX . MONTH DAY YEAR 1:25 M. 7 26 1985	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/auto impact				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road	21f. LOCATION STREET Rts. 309 & 404	CITY OR TOWN	COUNTY	STATE	MD.
<p>22a. I certify that I took charge of the remains described above, held as Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <i>Howard Smith</i> TITLE (SPECIFY) M.D. Acting Chief MEDICAL EXAMINER</p>							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St. Balto. MD.			DATE SIGNED 8/3/85		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-4-1985	23c. NAME OF CEMETERY OR CREMATORIAL Salisbury Crematory		23d. LOCATION CITY OR TOWN Salisbury, Wicomico, Md.	COUNTY	STATE
24. FUNERAL DIRECTOR Newnam Funeral Home		ADDRESS Easton, Md.	25a. DATE REC'D. BY REGISTRAR AUG 8 1985		25b. REGISTRAR'S SIGNATURE <i>Jane Davidson-Pondella</i>		

400255

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death.

Retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completed (Item 1 should be detached for use as the burial/transit permit Then please remove carbon paper, Pages 1 and 2 should be retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal).

IMPORTANT If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										22 / 96							
										REG. NO.							
1 - FOR STATE REGISTRAR		1a. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
5		LILLIAN			M.				WOODEN		8/18/85					5:25 P.M.	
3 SEX		4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
F		Caucasian			MONTH DAY YEAR			55			MONTHS DAYS		HOURS MIN.				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
BALTO. MD.		U.S.A.			BALTIMORE CITY -												
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
BALTO.		MASON LORD NURSING HOME			INSPECTOR			STEEL									
13a STATE MD.		13b COUNTY BALTO.		13c CITY OR TOWN BALTO.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 2400 MAPLE RD. 21219									
14 FATHER'S NAME JOSEPH		MIDDLE WOODEN		15. MOTHER'S MAIDEN NAME LILLIAN HODGES													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 212-28-0930		17 INFORMANT Mrs. Mary S. McNear - 807 Lennerton Rd.													
18 CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ANGST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>										
21d INJURY OCCURRED AT WHILE WORK <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a I certify that (I) (we) attended the deceased from 11/10/85, 19 84, to 8/18/85, 19 85, that (I) (we) last saw the deceased alive on 8/17/85, 19 85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE John D. Voss MD		22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 8/19/85						
22d PHYSICIAN'S NAME (TYPE OR PRINT) John D. Voss MD		22e ADDRESS FISKE BAPT. HOSP 28															
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-12-85		23c. NAME OF CEMETERY OR CREMATORIUM DULANEY VALLEY CEM.			23d. LOCATION CITY OR TOWN BALTO., MD		COUNTY		STATE						
24 FUNERAL DIRECTOR Hortley Miller - 7527 Harford Rd.		ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 12 1985		25b. REGISTRAR'S SIGNATURE Julia Leidman-Pedell										
DHMH - 16 60M 7/84 (VRA 15, 4)																	

21035

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224072

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22791

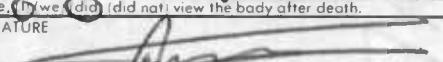
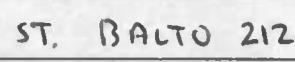
REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR			
				Edward		Woodland					8	7	85	1:00 AM			
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
M		B		MONTH DAY YEAR				62				MONTHS DAYS		HOURS MIN			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
BALTIMORE		UNIV. OF MARYLAND HOSP.				Longshoreman				MD.							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS / ZIP CODE					
MD				Balto.				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				1063 N. Stricker St., 21217					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				FIRST	MIDDLE	LAST	ADDRESS					
John			Anderson		Julie					Sample		1036 N. Stricker St. (17)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT				18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u>							
NO		219-16-9242				Frances Woodland				DUE TO, OR AS A CONSEQUENCE OF (b) <u>SEIZURE?</u> (c) <u>OAT CELL CARCINOMA.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				22a. DATE SIGNED <u>8/7/85</u>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/7/85</u> to <u>8/7</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>8/7/85</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.		22b. SIGNATURE <u>Varma, MD</u>				DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Varma</u>		22e. ADDRESS <u>3 UMS</u>				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE <u>8/12/85</u>				23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Auburn Cem.</u>			
BP		23d. LOCATION CITY OR TOWN <u>Westport</u>				23e. COUNTY <u>Md.</u>				24. FUNERAL DIRECTOR NAME <u>Chas.A.Rice FSPA 1300 Eutaw Place</u>				25a. DATE REC'D. BY REGISTRAR <u>AUG 8 1985</u>			
DHMH - 16 60M 7/B4 (VRA 15, 4)		25b. REGISTRAR'S SIGNATURE <u>Wendell</u>															

22 / 98

REG. NO.

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.		
GEORGE			W.	WOODY		AUG.18,1985		
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 1900		2a. DATE OF DEATH MONTH DAY YEAR AUG.18,1985		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 85 IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		
9. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION STEELWORKER		12b. KIND OF BUSINESS OR INDUSTRY ARMCO STEEL		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MARYLAND						13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 3800 W. BELVEDERE AVENUE
14. FATHER'S NAME FIRST UNKNOWN			15. MOTHER'S MAIDEN NAME MIDDLE CORA			LAST UNKNOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO 213-09-1242			17. INFORMANT ADDRESS ALICE WOODY, 3800 BELVEDERE AVENUE		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MIN		
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC PROSTATE CANCER						10 yrs.		
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/16</u> , 19 <u>85</u> , to <u>8/18</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>August 17, 1985</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)		22b. SIGNATURE 		22c. DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22d. DATE SIGNED <u>8/18/1985</u>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT) A. TOGIAS		22f. ADDRESS 1535 MC ELDERY ST. BALTO 2120						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-22-1985	23c. NAME OF CEMETERY OR CREMATORIAL MARYLAND NATIONAL		23d. LOCATION CITY OR TOWN LAUREL, MARYLAND	23e. COUNTY STATE		
24. FUNERAL DIRECTOR NUTTER & SONS FUNERAL HOME, INC. 2501 GWYNNS FALLS PARKWAY		25a. DATE REC'D. BY REGISTRAR AUG 27 1985			25b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon paper from the back of this certificate and mail it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22799

REG. NO.

DECEDENT'S NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
GEORGE J WOUTILA						AUGUST 9, 1985				P 1:02 M			
3. SEX		4 RACE		5 DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Male		White		7	24	1917	60	YRS	MONTHS	IF UNDER 21 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
New Jersey		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			BALTIMORE CITY			MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
BALTIMORE		JOHNS HOPKINS HOSPITAL								12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b STATE		13c COUNTY		13d CITY OR TOWN		13e INSIDE CITY LIMITS?		13f STREET ADDRESS / ZIP CODE					
Md.		Balto.		Essex		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		42 Ridgemoor Rd. 21221					
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME											
utuo		Katri											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO		116092764		Mary Lee Woutila		42ridgemoorrd.21		10 minutes					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)													
PART I. DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (1a) <u>Cardiac Arrest</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(1b) <u>Atrial-ventricular block</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(1c) <u>Malignant pseudonymoxoma peritoneum</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
Respiratory Failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
4/19/85		Small Bowel Obstruction		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>4/19</u> , 19 <u>85</u> , to <u>8/9</u> , 19 <u>85</u> , that (1) (we) last saw the deceased alive on <u>8/9</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		DATE SIGNED			
Steven C. Marks, MD										8/19/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Steven C. Marks		7015-H Lachlan Circle, Balto, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		8/13/85		Oak Lawn		Baltimore Md.							
24 FUNERAL DIRECTOR		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRATION NUMBER							
Connelly Funeral Home		300 Paca St. Baltimore Md. 21221		AUG 16 1985		14-14000-1							

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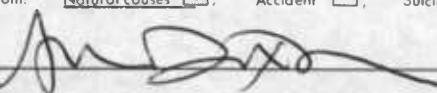
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH COPIES OF PAGES 1, 2, AND 3. RETAIN PAGES 3 & 4 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 - STATE REGISTRAR		2 - REG. NO. 22800									
T. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED DEATH		MONTH DAY YEAR	
ANNA						WRIGHT		<input checked="" type="checkbox"/> 8 8 1985		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
Female		White		May 29 1915		70					
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		10. CITY OR TOWN OF DEATH		11. CITIZEN OF WHAT COUNTRY?		12. DATE PRONOUNCED DEAD		13. DATE OF BUSINESS OR INDUSTRY			
Maryland		Baltimore		U.S.A.		8 8 1985		Post Office			
14. FATHER'S NAME FIRST MIDDLE LAST											
Hugh				Farrell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)		ADDRESS			
NO		214-03-3234		Mrs. Anne Nicodemus		21043					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED			
Ann M. Dixon, M.D.								8-8-85			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		Aug. 12, 1985		Baltimore National Cem.		Baltimore				Maryland	
24. FUNERAL DIRECTOR NAME		ADDRESS		21229		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HUBBARD FUNERAL HOME, INC.		4107 WILKENS AVENUE		AUG 9, 1985							

18025

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased physician be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use on the burial transit permit. Then please remove carbon paper, sign and attach to the State Dept. of Health and Mental Hygiene prior to burial. Certification on removal of this certificate from the deceased physician's office is a traumatic event, if medical records are required, attach them to the back of this certificate.

IMPORTANT: If Item 21 is marked as 'No' Item 18 shows any injury, or other traumatic event, the medical records will be required.

Film G607 item 4, 12a 12b
9/19/85 rjaSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

5 2 2 8 0 1

REG. NO.

1- FOR
STATE
REGISTRAR10
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
SHIRLEY Ann WRIGHT						AUGUST	26	, 1985		07:50AM	
1. SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS		
Female	White Negro	MONTH	DAY	YEAR	45	MONTHS	YEARS		MONTHS	HOURS	MIN.
4 21 40					45						
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				BALTIMORE CITY						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OR PRINT) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Factory Home</i>		
BALTIMORE			THE JOHNS HOPKINS HOSPITAL								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE					
Maryland	Caroline	Henderson	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1 Box 140			21640		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	ADDRESS	
William	J.		Hutchins, Sr.	Minnie					Henry	McLaurin Dover, DE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no	220-36-9011	Peggy Hutchins/			70 minutes						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Radiation Pneumonitis</i> 3 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) 70 minutes											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>August 13, 1985</i> to <i>August 26, 1985</i> , that (I) (we) last saw the deceased alive on <i>August 26, 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John E. Bolton</i> DEGREE											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22f. DATE SIGNED <i>8/26/85</i>			
Glenn Bolton		4940 Eastern Ave.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		8-30-85		Union Cemetery		Goldsboro		CA		MD	
24. FUNERAL DIRECTOR NAME <i>John E. Boulais</i> ADDRESS <i>Greensboro, MD</i>											
25a. DATE REC'D. BY REGISTRAR <i>Aug 30 1985</i>								25b. REGISTRAR'S SIGNATURE <i>John E. Boulais</i>			

SEARCHED



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

22802

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			Lorene B.		Wroe	-		8/14/85	8 25 PM			
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE	IN YEARS LAST BIRTHDAY		IF UNDER 1 YEAR			
F		W	MONTH	DAY	YR	66	MONTHS	WEEKS	# UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH	MD					
Maryland		U.S.A.	<input checked="" type="checkbox"/> MARRIED	<input type="checkbox"/> NEVER MARRIED	<input type="checkbox"/> WIDOWED	Baltimore City						
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
		Baltimore			Sinai Hospital			Housewife				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			
Md		Baltimore City		Glyndon		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			4724 Butler Rd. 21071			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT	
		Earnest		Burch	Lorena			220-01-6368			Philip C. Wroe Jr.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			16c. PLACE OF DEATH					
No							4724 Butler Rd.					Deaths
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											5 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory Failure											5 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Met. Colon Ca to lung + pleura.											2 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											2 yrs.	
None												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from 7/29/85 to 8/14/85, that (I) (we) last saw the deceased alive on 8/14/85 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											22b. DATE SIGNED	
22b. SIGNATURE		22c. DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR	STAFF PHYSICIAN	22d. DATE SIGNED		
Julie Gershon MD										8/14/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
Julie Gershon, MD		Sinai Hosp. of Baltimore										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION		23e. DATE REC'D. BY REGISTRAR			
Burial		Aug. 17, 1985		All Saints Cem.			Reisterstown, Baltimore		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			Eckhardt Funeral Chapel			25. REGISTRAR'S SIGNATURE				
Larry Fichtinger		Owings Mills, Md.			AUG 19 1985			J. Richardson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified.

Dates

Report
the subject was
not seen in
the area.

and arrived in 70% of park
and staying there
in 50% time

226093

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

22803

REG. NO.

1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
JULIA				G.	WYSOCKI		<input checked="" type="checkbox"/>	8-9-85	19	M	2d HOUR
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d HOUR
7	W	March 9 1915	70 yrs.				8-9-85	19	8:49A	M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Md.		USA					Baltimore City				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		320 S. Chester St.			Factory worker		21231				
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 320 S. Chester Street			
14. FATHER'S NAME FIRST Antoni		MIDDLE		LAST Wysocki		15. MOTHER'S MAIDEN NAME FIRST Alexandra		LAST Wisniewski			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS		17. INFORMANT		ADDRESS			
NO		215-05-7552		Theresa Wysocki 320 S. Chester St.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease											
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> <u>lying cause last.</u>											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Marguerite A. Korell, M.D.			TITLE (SPECIFY) Assistant		M.D.		MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)		Marguerita A. Korell, M.D.			ADDRESS		111 Penn Street				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 8-12-85		23c. NAME OF CEMETERY OR CREMATORIAL Holy Rosary Cemetery		23d. LOCATION Baltimore		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME John M. Weber & Sons Inc.		ADDRESS 401 S. Chester St.		25. DATE REC'D. BY REGISTRAR AUG 12 1985		25. REGISTRAR'S SIGNATURE June Davidson-Pandell					
BP											
DHMH - 17 (VR A15 ME (5))											

CCORSS

22804

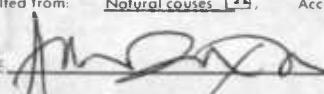
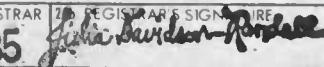
REG. NO.

1- STATE
REGISTRAR

234048

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 4. PAGE 4 SHOULD BE FORWARDED TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AT THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
AGNES			E.	YATES		<input checked="" type="checkbox"/>	8	14	19	85
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR
FEMALE	BLACK	1923 10 21 1923	61 yrs.			8	15	19	85	9:29 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		Baltimore City			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY
Baltimore		2442 Lakeview Ave.					RETIRED CLERK			C & P
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2442 LAKEVIEW AVENUE,		
14. FATHER'S NAME CLARENCE		MIDDLE A.	LAST YATES	15. MOTHER'S MAIDEN NAME GERTRUDE				LAST GOUGH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. NO		17. INFORMANT		ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		216-18-7964		JOYCE TILLMAN, 4009 SPRUCE DRIVE, 21215						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										
ACTUAL SIGNATURE 										
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-22-1985		23c. NAME OF CEMETERY OR CREMATORIUM ARBUTUS MEMORIAL PARK		23d. LOCATION CITY OR TOWN BALTIMORE COUNTY			COUNTY STATE	
24. FUNERAL DIRECTOR NAME FLETCHER & SONS FUNERAL HOME, INC. ADDRESS 2501 GWYNNS FALLS PARKWAY		25a. DATE REC'D. BY REGISTRAR AUG 20 1985		25b. REGISTRAR'S SIGNATURE 						

BRUNO

RENT NOTICE NO.

248109

22805

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			EDWARD	F.	YONKEE	8/27/85	00	27	1985	6 ²⁸ AM	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
MALE		WHITE	MONTH	DAY	YEAR	IF UNDER 1 YEAR	MONTHS	DAYS	IF UNDER 24 HRS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
PENN.		U.S.A.						BALTIMORE CITY MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		FRANCIS SCOTT KEY MEDICAL CENTER									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MD				BALTIMORE				3927 E. LOMBARD ST, 21224			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	ADDRESS			
EDWARD			YONKEE	EMMALINE		SCHOFIELD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> NO		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
		220-22-2537				HEPATO-RENAL SYNDROME					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE LIVER DISEASE		(c)							
DUE TO, OR AS A CONSEQUENCE OF (b) END STAGE LIVER DISEASE											
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from Aug. 26, 1985, to Aug. 27, 1985, that (I) (we) last saw the deceased alive on Aug. 27, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE					DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED		
Neal T. Sakima MD									8/27/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS						
NEAL T. SAKIMA MD.					Francis Scott Key Med. Ctr.						
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ESTATE		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
CREMATION		8-29-85		GREENMOUNT		BALTIMORE MD		SEP 3 1985		John Davidson Pendleton	
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. FUNERAL DIRECTOR NAME		25b. ADDRESS			25c. FUNERAL DIRECTOR NAME	
Raymond L. Kaczorowski		2525 Fleet St.									

COLLAGE



219086

22300

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

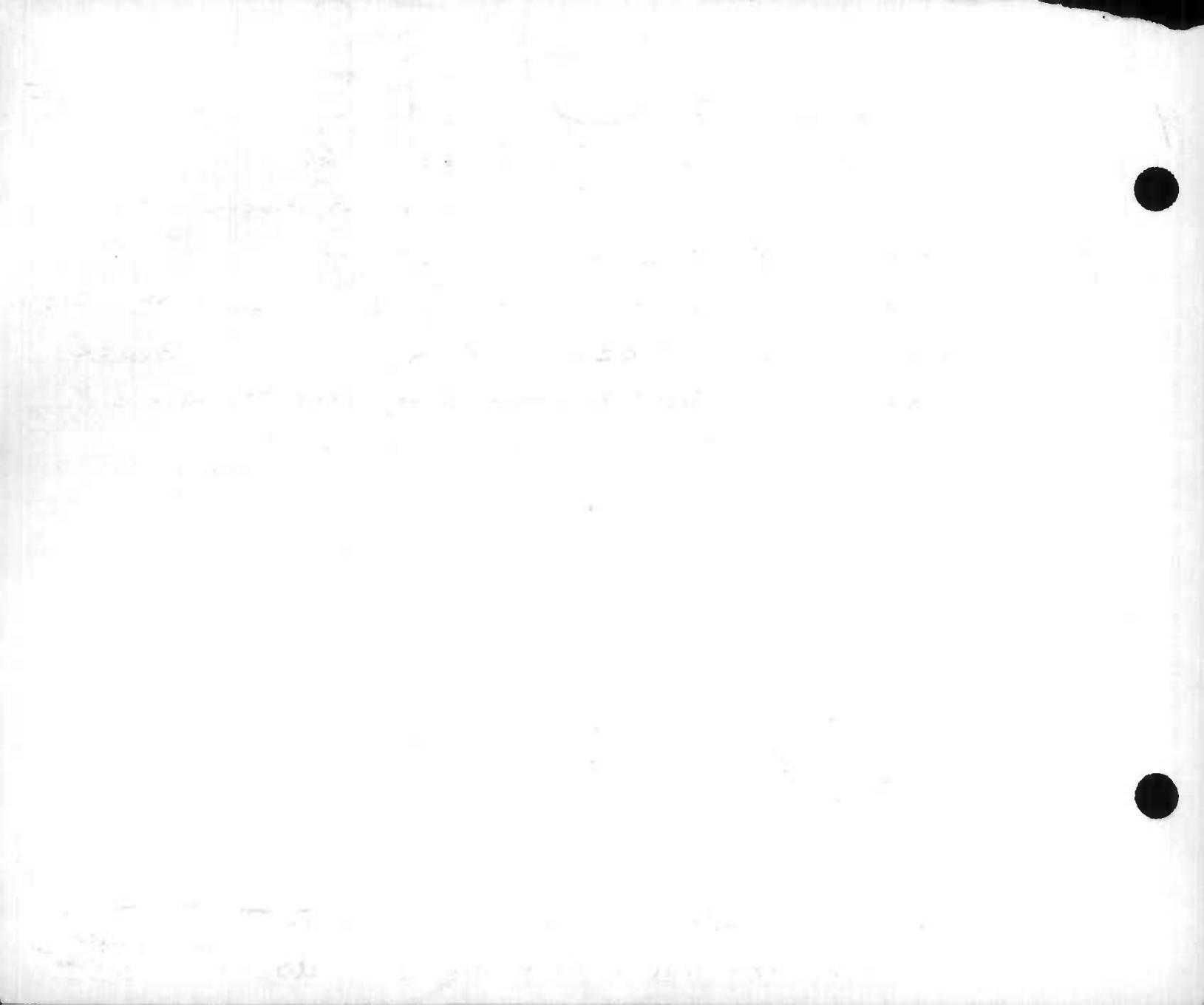
REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	20b. HOUR		
<i>Leola</i>			<i>7.</i>	<i>Young</i>		<i>8</i>	<i>1</i>	<i>85</i>		<i>11 AM</i>		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>Female</i>		<i>Black</i>		<i>12</i>	<i>9</i>	<i>24</i>	<i>60</i>	YRS.	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
<i>Va.</i>		<i>USA</i>				<i>Baltimore City</i>						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
<i>Baltimore</i>		<i>J. L. Deaton Medical Center</i>										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE				
<i>MD</i>				<i>Baltimore</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<i>611 S. Charles St.</i>		<i>21230</i>		
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST					
<i>William</i>		<i>C.</i>	<i>Booze</i>	<i>Daisy</i>			<i>Booze</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>NO</i>		<i>219-18-4317</i>		<i>Leola Young</i>		<i>4428 St. George</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the breast C hordeum metastasis</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>June 5 1985</i> to <i>Aug 1 1985</i> , that (II) (we) lost the deceased alive on <i>Aug 1 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (III) (we) did (did not) view the body after death.												
22b. SIGNATURE <i>J.W. Reed</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J.W. Reed</i>		22e. ADDRESS <i>611 S. CHAS. ST. BALTIMORE MD 21230</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>8/6/85</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>King Mem. Pk.</i>		23d. LOCATION CITY OR TOWN <i>Baltimore Co. MD</i>		23e. COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <i>Wm. C. March</i>		ADDRESS <i>E/14 1101 E. North Ave</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 5 1985</i>		25b. REGISTRAR'S SIGNATURE <i>Jeanne Dawson-Randall</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



217040

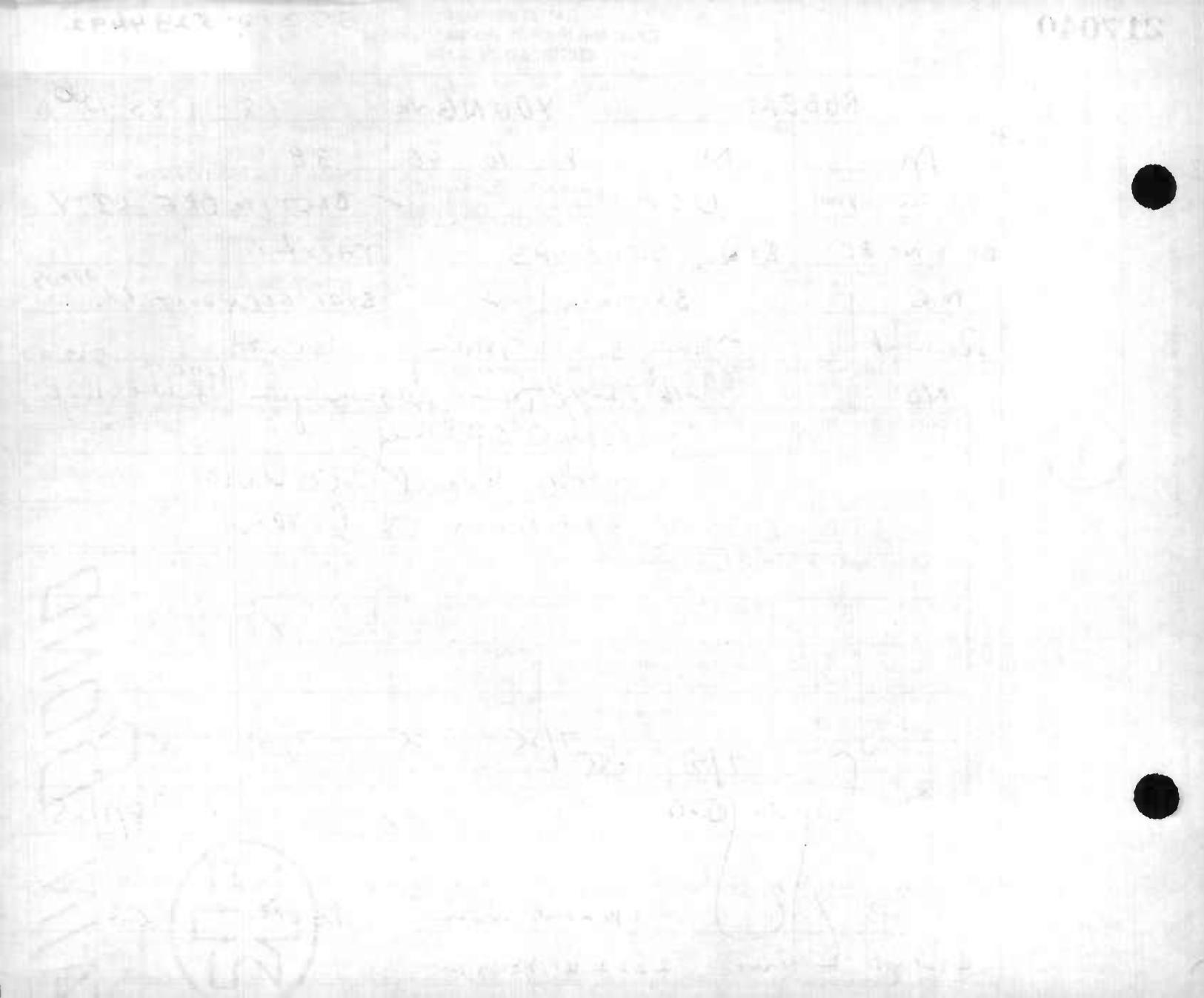
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove both pages 3, Page 4 and 2 (which will be used for the 24 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal).

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 85-22807		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
ROBERT			YOUNG JR			8 1 85			120 AM			
3. SEX M			4 RACE N			5. DATE OF BIRTH MONTH 8 DAY 10 YEAR 46			6. AGE (IN YEARS LAST BIRTHDAY) 38			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md			7b. CITIZEN OF WHAT COUNTRY? USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10 CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) mod.			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md			13b. COUNTY BALTIMORE			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 3921 GLEN HUNT Rd. 21229			
14. FATHER'S NAME Robert			15. MOTHER'S MAIDEN NAME young sa may scott									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) NO			16b. SOCIAL SECURITY NO. 216-52-449			16c. EMPLOYMENT HOSPITAL			ADDRESS 4009 21247			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>meningitis</u> Conditions, if any, which gave rise to immediate cause (b) <u>hypertension</u> stating the underlying cause last. (b) <u>meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>meningitis</u>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (his hospital) attended the deceased from 7/31 1985 to 7/31 1985, that (I) (we) last saw the deceased alive on 7/31 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (had) (did) not view the body after death.												
22b. SIGNATURE <u>P. J. Geesey</u>			22c. DEGREE D.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8/1/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B			23c. NAME OF CEMETERY OR CREMATORIAL WORD LAWNS			23d. LOCATION STREET			23e. COUNTY CO STATE			
24. FUNERAL DIRECTOR NAME Joseph Russ			ADDRESS 2222 W York St			25a. DATE REC'D. BY REGISTRAR AUG 1 1985			25b. REGISTRAR'S SIGNATURE Hendee			



232071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 2 and 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medicolegal unit must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												22808				
												REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH									2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE	LAST	MONTH			DAY	YEAR	5:06 AM			
Robert Alston 76411								10			15	85				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Black			MONTH DAY YEAR			75			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
S.C.			USA						Baltimore City							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore			Francis Scott Key Hosp.													
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS / ZIP CODE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MD			Baltimore		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7205 Orth Rd. 21219						
14. FATHER'S NAME			MIDDLE			LAST	15. MOTHER'S MAIDEN NAME			ADDRESS			LAST			
John			S.			Young	Pernella			Johnny Young 3624 Bellmore Rd.			Alston			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT										
No			217-01-4460													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____																
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____																
DUE TO, OR AS A CONSEQUENCE OF (c) _____ Ischemic Heart Disease																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)										
			P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 15, 1985, to Aug 15, 1985, that (I) (we) last saw the deceased alive on Aug 15, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED				
Sanford Schaps MD												8/15/85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									Francis Scott Key Hospital, Baltimore, MD 21224				
Sanford Schaps MD																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			8/19/85			Holly Hills Cem.			White Marsh				MD			
24. FUNERAL DIRECTOR NAME			ADDRESS									25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. C. March F/H			1101 E. North Ave.									AUG 16 1985		John Schaps		

170000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial permit. Then please remove carbon paper. If item 21 is marked or item 18 shows any injury, or other traumatic event, the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22809

REG. NO.

1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	26. HOUR				
JOSEPH				J.		ZANGARA	AUGUST 23, 1985				5:52 P.M.				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
Male		White		MOTH 7-26-1916 YEAR		69 YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY			
Baltimore, Md.		U.S.A.		8											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
BALTIMORE		JOHNS HOPKINS HOSPITAL		Salesman		Retired									
13a. STATE Md.												13b. COUNTY Baltimore			
13c. CITY OR TOWN Baltimore												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 5003 Plainfield Ave. - 21206															
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST					
Joseph Zangara						Carolina Penna									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Yes		WWII		217-05-6393		Mrs. Frances J. Zangara 5003 Plainfield Ave									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____															
DUE TO, OR AS A CONSEQUENCE OF _____															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>abdominal aortic aneurysm</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>85</u> , to <u>8/23</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.															
22b. SIGNATURE <u>Mindy Shapiro</u>		22c. DATE SIGNED <u>8/23/85</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Shapiro, Mindy</u>		22e. ADDRESS JHH 600 N. Wolfe St													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-85		23c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus Ceme.		23d. LOCATION CITY OR TOWN Balto. Md		COUNTY	STATE						
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206		25a. DATE REC'D. BY REGISTRAR AUG 26 1985		25b. REGISTRAR'S SIGNATURE J. Maranson-Henderson											
BP _____															
DHMH - 16 60M 7/84 (VRA 15, 4)															

FOOTERS

WATER

SWELL

WAVELET

WAVELET, SWELL, WIND

WAVELET

WAVELET, SWELL, WIND

WAVELET

241052

22810

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - STATE
REGISTRAR

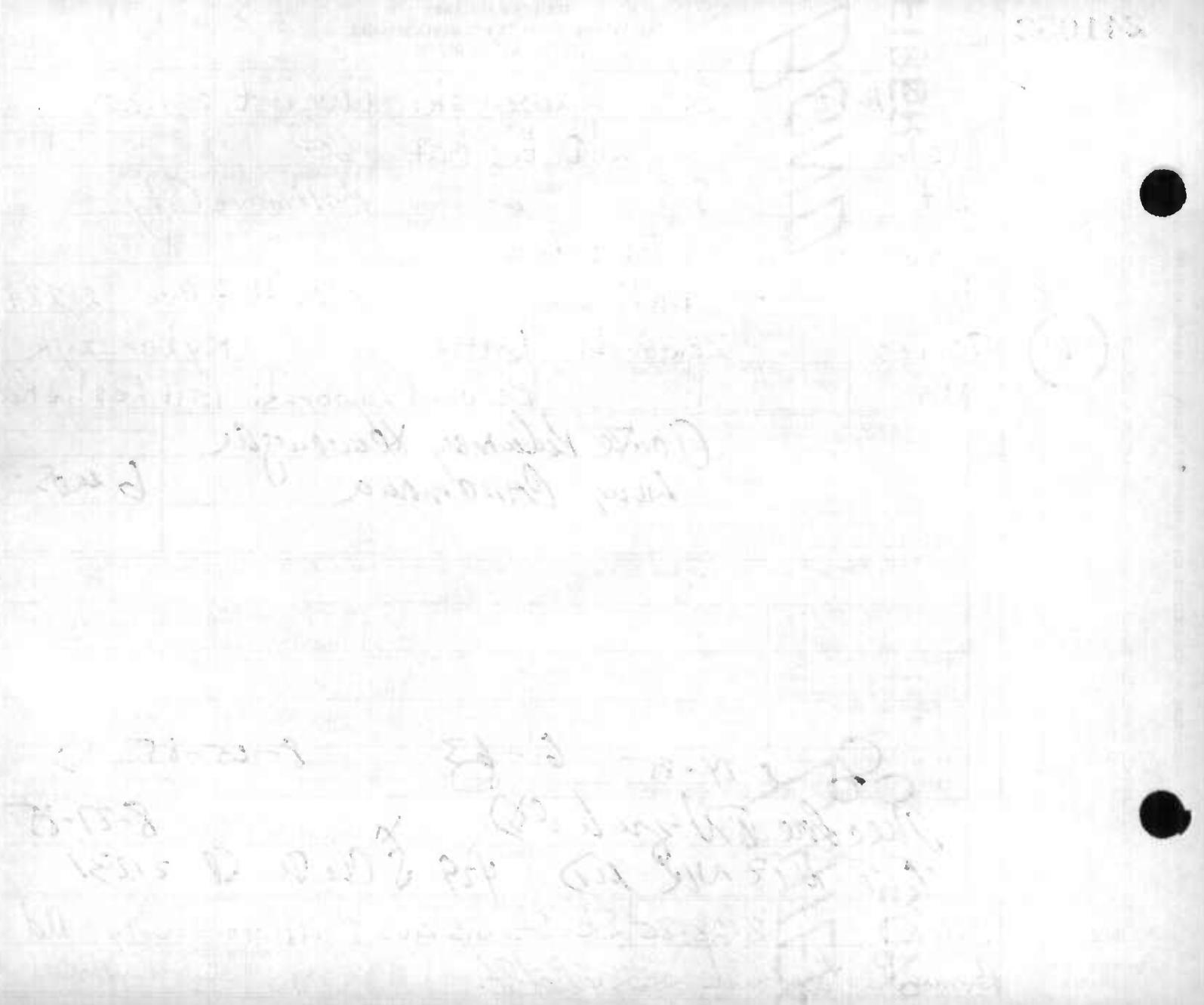
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
<i>Albert</i>			<i>S.</i>	<i>Zaworski</i>		<i>August 26, 1985</i>					
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	M			
<i>Male</i>		<i>Caucasian</i>	MONTH	DAY	YEAR	<i>60</i>	IF UNDER 24 HRS	MONTHS	DAYS	HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
<i>MD</i>		<i>U.S.A.</i>					<i>Baltimore City, MD</i>				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
<i>Baltimore</i>		<i>2702 Fair Ave</i>									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
<i>MD</i>		<i>—</i>		<i>Baltimore</i>				<i>2702 Fair Ave 21224</i>			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	ADDRESS			
<i>James</i>			<i>Zaworski</i>	<i>Lottie</i>			<i>Rybarczyk</i>	<i>Bernard Zaworski 1511 Leslie Rd</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>No</i>											
II. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Acute Pulmonary Thromboglie</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Lung Carcinoma</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (his hospital) attended the deceased from <i>8-24-85</i> to <i>6-23-85</i> , to <i>8-25-85</i> , that (I) (we) last saw the deceased live on <i>8-24-85</i> at <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE <i>Theodore P. Rybarczyk DO</i> DEGREE <i>MD</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22f. DATE SIGNED <i>8-27-85</i>				
<i>T. P. Rybarczyk MD</i>		<i>429 S Charles St 21231</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR OWN		23e. COUNTY STATE		
<i>Burial</i>		<i>8-28-85</i>		<i>St. Stanislaus</i>			<i>Baltimore City, Md</i>				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
<i>Raymond L. Kaczowski 2525 Lloyd St.</i>					<i>AUG 27 1985</i>		<i>Johanna Sanderson Pendleton</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)



234092

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

22811

1 -
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Helen Quackenbush Zepp						8	17	85	4:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				
Female		White		MONTH	DAY	YEAR	78	IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Indiana		U.S.A.		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Baltimore City		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT INSTITUTION, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Baltimore		St. Agnes Hospital		Homemaker		Domestic				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		
Md.		Balto.		Catonsville				21228		
14. FATHER'S NAME		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
Clarence		Alvin	Quackenbush	Mary		Catherine		Dedyre		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Pulmonary Arrest</u>		19-E Montrose Manor Ct. Catonsville Md 21228		
No		213-74-7484		Willard E. Zepp						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Pulmonary Arrest</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive Pulmonary Disease</u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Urinary tract infection</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>Aug 16</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>B. Atac</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Atac		22e. ADDRESS		22f. DATE SIGNED						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b. DATE 8-19-85		23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Pk.		23d. LOCATION CITY OR TOWN Catonsville		COUNTY STATE Balto. Md.		
24. FUNERAL DIRECTOR NAME SLACK FUNERAL HOME		ADDRESS Box 268 Ellicott City, Md 21042		25a. DATE REC'D. BY REGISTRAR AUG 20 1985		25b. REGISTRAR'S SIGNATURE J. L. Johnson-Parker				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use in the burial permit. Then please remove carbon papers. Page 4 should be filed in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury or other traumatic event, the medical examiner must be notified.

Synopsis.